

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 4

## 1. PLACE OF DEATH:

COUNTY Allegany MARYLAND  
 CITY (If outside corporate limits, write RURAL OR and give nearest town) Cumberland LENGTH OF STAY (in this place) 10 Months  
 TOWN Cumberland  
 HOSPITAL OR INSTITUTION OR STREET ADDRESS 313 Bedford St.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY Allegany  
 CITY (If outside corporate limits write RURAL and give nearest town) Cumberland  
 TOWN Cumberland  
 STREET ADDRESS (If rural, give location) 313 Bedford St.

## 3. NAME OF DECEASED:

(First) (Middle) (Last)  
Charles Richard Abe

4. DATE OF DEATH (Month) (Day) (Year)  
July 4 19 55

## 5. SEX:

male

## 6. COLOR OR RACE:

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

## 8. DATE OF BIRTH:

Dec. 11-1917

## 9. AGE last birthday:

37 yrs.

## IF UNDER 1 YEAR IF UNDER 24 HRS.

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, etc. if retired)  
Mill worker

10b. KIND OF BUSINESS OR INDUSTRY:  
Taylor Lumber Co.

11. BIRTHPLACE (State or foreign country):  
Cumberland, Md.

12. CITIZEN OF WHAT COUNTRY?  
U.S.A.

## 13. FATHER'S NAME:

Joseph H. Abe

## 14. MOTHER'S MAIDEN NAME:

Frances Ogden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)  
yes W.W.2

16. SOCIAL SECURITY No.:  
214-07-1828

17. INFORMANT & ADDRESS:  
(sister) Evelyn Cavey, Cumberland, Md.

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Intracranial hemorrhage due to a 22 short  
 DUE TO rifle bullet in head.  
 Antecedent cause(s) (b)  
 Diseases or conditions, if any, giving rise to the above cause DUE TO  
 stating underlying cause last (c)

INTERVAL BETWEEN ONSET AND DEATH  
sudden

## II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

## 19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY Home

21c. (City or town) (County) (State)  
Cumberland Allegany Md.

21d. TIME (Month) (Day) (Year) July 4/55 P. M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☒

21f. HOW DID INJURY OCCUR?  
Laid on bed & shot himself in right temporal region.

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

H.V. Deming M.D.

CHIEF MEDICAL EXAMINER ☐ DATE SIGNED July 4-1955  
 DEPUTY MEDICAL EXAMINER ☐  
 ASSISTANT MEDICAL EXAM. ☐

23. BURIAL, CREMATION, REMOVAL (Specify):  
Burial

DATE THEREOF July 7, 1955 NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery LOCATION (City, town, or county) (State)  
Cumberland, Maryland

DATE REC'D BY LOCAL REG.  
July 5, 1955

REGISTRAR'S SIGNATURE  
Walter L. Frantz, M.D.

24. FUNERAL DIRECTOR ADDRESS  
Chas. L. George, Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 7 1975

BUREAU A. S.

6089

## CERTIFICATE OF DEATH

06096

Reg. Dist. No. 4

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Allegheny</u>		MARYLAND		STATE <u>Pa.</u>		COUNTY <u>Allegheny</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cumberland</u>		<u>1 wk.</u>		TOWN <u>LeVale, Cumberland</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>62 Sacred Heart Hospital</u>				<u>1</u>			
<b>3. NAME OF DECEASED</b>				<b>4. DATE OF DEATH</b>			
(First) <u>Sophia</u> (Middle) <u>Agness</u> (Last) <u>Agness</u>				(Month) <u>July</u> (Day) <u>17</u> (Year) <u>19 55</u>			
<b>5. SEX</b>		<b>6. COLOR OR RACE</b>		<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>		<b>8. DATE OF BIRTH</b>	
<u>Female</u>		<u>White</u>		<u>Married</u>		<u>3/31/90</u>	
<b>9. AGE last birthday</b>		<b>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>9. AGE last birthday</b>	
<u>65</u> yrs.		<u>Housewife</u>		<u>Own home</u>		<u>65</u> yrs.	
<b>11. BIRTHPLACE (State or foreign country)</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b>		<b>11. BIRTHPLACE (State or foreign country)</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<u>Austria</u>		<u>AUSTRIA</u>		<u>Austria</u>		<u>AUSTRIA</u>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>John Tkachuk</u>				<u>Helen Sara Finuk</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)</b>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<u>NO</u>		<u>None</u>		<u>Patient's chart</u>			
<b>18. MEDICAL CERTIFICATION</b>							
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>							
584X IMMEDIATE CAUSE (A) <u>acute pancreatitis</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>cholelithiasis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b> <u>7-15-55</u> <b>19b. MAJOR FINDINGS OF OPERATION</b> <u>pancreatitis, common duct stones, cholelithiasis</u>							
<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town)</b>		<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>	
<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>		<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>	
<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
<b>22. I hereby certify that I attended the deceased from <u>3-4-</u>, 19<u>54</u>, to <u>7-17</u>, 19<u>55</u>, that I last saw the deceased alive on <u>7-17-</u>, 19<u>55</u>, and that death occurred at <u>12:00 P.</u>, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>L. Morris</u>				<b>DATE SIGNED</b> <u>7-17-55</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>				<b>24. REC'D BY REGISTRAR</b>			
<u>Burial</u>				<u>July 19, 1955</u>			
<b>DATE THEREOF</b>				<b>REGISTRAR'S SIGNATURE</b>			
<u>July 20, 1955</u>				<u>Walter R. Frank, M.D.</u>			
<b>NAME OF CEMETERY OR CREMATORY</b>				<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>			
<u>Hillcrest Bur. Park</u>				<u>John J. Hafer, Cumberland, Maryland</u>			
<b>LOCATION (City, town, or county)</b>				<b>ADDRESS</b>			
<u>Cumberland, Maryland</u>				<u>Cumberland, Maryland</u>			

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

## RECEIVED

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

6790

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		MARYLAND		STATE MARYLAND		COUNTY ALLEGANY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN CUMBERLAND		7 DAYS		TOWN RURAL CUMBERLAND		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
60 MEMORIAL HOSPITAL MEMORIAL AVENUE				RT. #3, BEDFORD ROAD			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) (Middle) (Last)							
OLIVER George ALDRIDGE				JULY 14, 1955			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
MALE	WHITE	MARRIED	MARCH 6, 1902	53 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Brickmaker		B+O Railroad		MARYLAND, Mt. Savage		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
OLIVER ALDRIDGE				LOTTIE BRIDGES			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No		705-05-5220		MEMORIAL HOSPITAL, CUMBERLAND, MD.			

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
581.0 IMMEDIATE CAUSE (A)				Cir. brain of liver and Cardia			
ANTECEDENT CAUSE(S) DUE TO				Vascular Disease with Marked			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE				Ascites		Unknown	
STATING UNDERLYING CAUSE LAST. DUE TO (C)						Sw. Yers.	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			

22. I hereby certify that I attended the deceased from Jan 5, 1955, to 14 July, 1955, that I last saw the deceased alive on 14 July, 1955, and that death occurred at 3:55 P.M. from the causes and on the date stated above.

SIGNATURE		ADDRESS (Street, city, town, state)		DATE SIGNED	
Custon Bunsford		232 Baltimore Ave.		July 15, 1955	
M.D.					
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)	
Burial	7/16/55	Hillcrest Cem.	Cumberland Md		
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE			
July 16, 1955	Winters R. Frantz, M.D.	John F. Hafer Cumberland Md			

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

# CERTIFICATE OF DEATH

DATE OF DEATH

1000

1000

1000

1000

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1000

1000

1000

1000

1000

1000

1000

BUREAU V. 3

JUL 19 1955

RECEIVED

1000

PHOTOGRAPH

# CERTIFICATE OF DEATH

6091

Reg. Dist. No. 4

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Allegany</u>		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>			
CITY OR TOWN <u>02 Cumberland, Md.</u>		LENGTH OF STAY (in this place) <u>1 Day</u>		CITY OR TOWN <u>02 Cumberland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>62 Sacred Heart Hospital</u>				STREET ADDRESS <u>443 Race St.</u>			
<b>3. NAME OF DECEASED</b>				<b>4. DATE OF DEATH</b>			
(First) <u>Delia</u> (Middle) <u>Arnold</u> (Last) <u>Arnold</u>				(Month) <u>July</u> (Day) <u>24</u> (Year) <u>1955</u>			
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Widowed</u>		<b>8. DATE OF BIRTH</b> <u>June 30 1885</u>	
<b>9. AGE last birthday</b> <u>70</u> yrs.		<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>			
		Months Days		Hours Min.			
<b>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b> <u>House Wife</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Own House</u>		<b>11. BIRTHPLACE (State or foreign country)</b> <u>Hampshire County W. Va.</u>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>							
<b>13. FATHER'S NAME</b> <u>Taylor Fultz</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Elizabeth Shanholts</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)</b> <u>No</u>				<b>16. SOCIAL SECURITY NO.</b> <u>None</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Mrs. Lucy Mellon, Keyser, W. Va. Sister</u>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>IMMEDIATE CAUSE (A)</b> <u>422.1 Cerebral Vascular Accident</u>						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>3</u>	
<b>ANTECEDENT CAUSE(S) (B)</b> <u>CONGESTIVE HEART FAILURE</u>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)</b> <u>Due to Arterio Sclerotic Cardiac Vascular Disease</u>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year)</b>		<b>21e. INJURY OCCURRED While at work Not while at work</b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from 3:30 PM 7/24/55, to 7:24 PM 7/24/55, that I last saw the deceased alive on 7/24, 1955, and that death occurred at 7:45 P.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>H. H. Hight</u>				<b>DATE SIGNED</b> <u>7/24/55</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>				<b>24. REGISTRAR'S SIGNATURE</b> <u>Walter R. Frantz, M.D.</u>			
<b>DATE THEREOF</b> <u>July 26, 1955</u>				<b>NAME OF CEMETERY OR CREMATORY</b> <u>Hillcrest Burial Park</u>			
<b>LOCATION (City, town, or county) (State)</b> <u>Cumberland, Md.</u>				<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>H. H. Hight</u>			
<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>H. H. Hight</u>				<b>ADDRESS</b> <u>Cumberland, Md.</u>			

BUREAU V.

JUL 28 1961

REF

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

## 1. PLACE OF DEATH:

COUNTY Allegheny MARYLAND  
 CITY (If outside corporate limits, write RURAL OR and give nearest town) Cumberland  
 TOWN Cumberland LENGTH OF STAY (in this place) 7 yrs.

HOSPITAL OR INSTITUTION OR STREET ADDRESS 216 Glenn St

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY Allegheny  
 CITY (If outside corporate limits write RURAL and give nearest town) Cumberland  
 TOWN Cumberland

STREET ADDRESS (If rural, give location) 216 Glenn St.

## 3. NAME OF DECEASED:

(First) (Middle) (Last)

(Type or Print) Priscilla

Barley

4. DATE (Month) (Day) (Year)

OF DEATH July 11 19 55

## 5. SEX:

## 6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH: 1871 Sept. 25-1861

9. AGE last birthday: 83 yrs.

IF UNDER 1 YEAR IF UNDER 24 HRS.  
 Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Seamstress

10b. KIND OF BUSINESS OR INDUSTRY: Dressmaker

11. BIRTHPLACE (State or foreign country): Clairsville, Pa.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

## 13. FATHER'S NAME:

Ruben Henry Barley

## 14. MOTHER'S MAIDEN NAME:

Matilda Bean

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)  
No

16. SOCIAL SECURITY No.: none

17. INFORMANT & ADDRESS: 216 Glenn St. (sister) Mrs. Lena Struckman, Cumberland, Md.

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

450.0

Immediate cause

(a)

Generalized arteriosclerosis

DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b)

DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH  
Sudden

## II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

## 19a. DATE OF OPERATION:

## 19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?  
 Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

21c. (City or town)

(County)

(State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

H.V. Deming M.D.

M. D.

CHIEF MEDICAL EXAMINER  
 DEPUTY MEDICAL EXAMINER  
 ASSISTANT MEDICAL EXAM.

DATE SIGNED

July 11-1955

23. BURIAL, CREMATION, REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

BurialJuly 13, 1955Nuthern CemeteryOsterburg, Pa.

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

July 12, 1955Walter L. Gantz, M.D.Louis Geisel Funeral Home, Bedford, Pa.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 2

JUL 14 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist.

No. 4

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>Allegany</b>	MARYLAND	STATE <b>Md.</b>	COUNTY <b>Allegany</b>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <b>Cumberland</b>	LENGTH OF STAY (in this place) <b>4 days</b>	CITY (If outside corporate limits write RURAL and give nearest town) TOWN <b>Cumberland</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Memorial Hospital</b>		STREET ADDRESS (If rural, give location) <b>333 Virginia Ave.</b>	
3. NAME OF DECEASED: (Type or Print) <b>Phillip Richard Barrett</b>		4. DATE OF DEATH <b>July 22 1955</b>	
5. SEX: <b>male</b>	6. COLOR OR RACE: <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>married</b>	8. DATE OF BIRTH: <b>Dec. 28-1890</b>
9. AGE last birthday: <b>64</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <b>Retired machinest B&amp;O, R. Ry.</b>	
11. BIRTHPLACE (State or foreign country): <b>Martinsburg, W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME: <b>John William Barrett</b>		14. MOTHER'S MAIDEN NAME: <b>Lulu Kief</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>no</b>		16. SOCIAL SECURITY No.: <b>705-05-4798</b>	
(If Yes, give war or dates of service)		17. INFORMANT & ADDRESS: <b>Memorial Hospital records &amp; daughter.</b>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
(a) <b>Lobar pneumonia</b>		<b>3 days</b>
Immediate cause DUE TO		
(b) <b>Delerium tremens</b>		<b>5 days</b>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last		
(c) <b>Chronic alcoholism</b>		<b>?</b>

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
<b>Incomplete fracture of the greater trochanter of right femur.</b>		<b>4 days</b>

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
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21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <b>512 Maryland St.</b>	21b. PLACE (Home, farm, factory, OR street, office bldg., etc.) <b>Cumberland Allegany Md.</b>	21c. (City or town) (County) (State)
--	--	--------------------------------------

21d. TIME (Month) (Day) (Year) (Hour) <b>July 18/55 P. M.</b>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>Lost balance, fell on concrete porch, struck right hip</b>
---	---	--

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE <b>H.V. Deming M.D.</b>	CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED <b>July 25-1955</b>
	DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
	ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	

23. BURIAL, CREMATION, REMOVAL (Specify): <b>Burial</b>	DATE THEREOF <b>7-25-1955</b>	NAME OF CEMETERY OR CREMATORY <b>Davis Memorial Hospital</b>	LOCATION (City, town, or county) (State) <b>Cumberland, Allegany, Md.</b>
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DATE REC'D BY LOCAL REG. <b>July 27, 1955</b>	REGISTRAR'S SIGNATURE <b>Winter R. Frantz, M.D.</b>	24. FUNERAL DIRECTOR ADDRESS <b>James F. Scarpelli, Cumberland, Md.</b>
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MARGIN RESERVED FOR BINDING

TWO FOR ONE CERT. - FILM 6189

8-1-JT

X3

BUREAU V. S.

JUL 29 1955

RECEIVED

6140

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. **06101**  
 No. **9**

## 1. PLACE OF DEATH:

COUNTY **Allegany** MARYLAND  
 CITY (If outside corporate limits, write RURAL OR and give nearest town) **12** **Frostburg**  
 TOWN **10 hrs.**

HOSPITAL OR INSTITUTION OR STREET ADDRESS **61** **Miners Hospital**

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE **Ohio** COUNTY **Summit**  
 CITY (If outside corporate limits write RURAL and give nearest town) **72X-3**  
 OR TOWN **Akron**

STREET ADDRESS (If rural, give location) **Crosier St.**

## 3. NAME OF DECEASED:

(First) (Middle) (Last)  
**Irvin Willard Bittner**

4. DATE OF DEATH (Month) (Day) (Year)  
**July 2 19 55**

## 5. SEX:

**Male**

## 6. COLOR OR RACE:

**White**

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)  
**Widower**

## 8. DATE OF BIRTH:

**Oct. 15-1885**

## 9. AGE last birthday:

**69**

IF UNDER 1 YEAR IF UNDER 24 HRS.  
 Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):  
**Boiler Maker-McNeil Machine & Eng. Co.**

10b. KIND OF BUSINESS OR INDUSTRY:  
**Kansas, Jackson Co.**

11. BIRTHPLACE (State or foreign country):  
**U.S.A.**

## 13. FATHER'S NAME:

**David Bittner**

## 14. MOTHER'S MAIDEN NAME:

**Sarah Ellen Shaffer**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)  
**no**

## 16. SOCIAL SECURITY No.:

**281-10-2563**

## 17. INFORMANT &amp; ADDRESS:

**Anna M. Bauer, Akron, Ohio.**

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

**823X**  
**Immediate cause**

(a) **Pulmonary hemorrhage due to punctured lungs 11 hrs.**

## Antecedent cause(s)

DUE TO

**from fractured ribs, right side of chest also**

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

DUE TO

(c) **had a fractured right clavicle. Auto. accident.**

## II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

## 19a. DATE OF OPERATION:

## 19b. MAJOR FINDING OF OPERATION:

INTERVAL BETWEEN ONSET AND DEATH  
**11 hrs.**

20. AUTOPSY?  
 Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, office, street, office bldg., etc.)  
**Roadway**

21c. (City or town) (County) (State)  
**Near-Grantsville Garrett Md.**

21d. TIME (Month) (Day) (Year) **11.30**  
**July 2-1955 A.M.**

21e. INJURY OCCURRED While at work ☐ Not while at work ☒

21f. HOW DID INJURY OCCUR? **Presume excessive speed, car careened across road and hit guard posts.**

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

## SIGNATURE

**H. V. Deming M.D.**

CHIEF MEDICAL EXAMINER ☐ DATE SIGNED **7-3-1955**  
 DEPUTY MEDICAL EXAMINER ☒  
 ASSISTANT MEDICAL EXAM. ☐

## 23. BURIAL, CREMATION, REMOVAL (Specify):

**Burial**

## DATE THEREOF

**7-6-55**

## NAME OF CEMETERY OR CREMATORY

**Chestnut Hill Cemetery**

## LOCATION (City, town, or county)

**Akron**

## (State)

**Ohio**

## DATE REC'D BY LOCAL

## REGISTRAR'S SIGNATURE

**7-3-55**  
**Mrs. Nancy A. Roe**

## 24. FUNERAL DIRECTOR

**Jacob Hafer, 23 E. Main, Frostburg, Md.**

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUL 11 1955

RECEIVED

06102

6094

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>ALLEGANY</b>		MARYLAND		STATE <b>MARYLAND</b>		COUNTY <b>ALLEGANY</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>02 TOWN CUMBERLAND</b>		LENGTH OF STAY (In this place) <b>20 1/2 HRS.</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>02 TOWN CUMBERLAND</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>60 MEMORIAL HOSPITAL, MEMORIAL &amp; WARWICK AVES.,</b>				STREET ADDRESS (If rural give location) <b>543 ARNETT TERRACE</b>		<b>02</b>	
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <b>LAURA</b> (Middle) <b>XXX MAY</b> (Last) <b>BLACKBURN</b>				<b>DEATH JULY 1920 1955</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>JULY 30 1881</b>	9. AGE last birthday <b>73</b> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>COLORADO</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>FREEMAN GRAHAM</b>				14. MOTHER'S MAIDEN NAME <b>ANNA E. ROBINSON</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT & ADDRESS <b>C. H. Graham, Moundsville, W. Va.</b>		
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <b>443X Cerebral Hemorrhage</b>				INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>			
ANTECEDENT CAUSE(S) DUE TO (B) <b>Hypertension C.V. Disease</b>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>July 19, 1955</b> , to <b>July 20, 1955</b> , that I last saw the deceased alive on <b>July 20, 1955</b> , and that death occurred at <b>1:00 P.</b> M, from the causes and on the date stated above.							
SIGNATURE <b>B. M. Schindler</b>		DATE THEREOF <b>July 22, 1955</b>		NAME OF CEMETERY OR CREMATORY <b>Zion Memorial Cemetery</b>		LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		DATE THEREOF <b>July 22, 1955</b>		NAME OF CEMETERY OR CREMATORY <b>Zion Memorial Cemetery</b>		LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
24. REC'D BY REGISTRAR <b>July 22, 1955</b>		REGISTRAR'S SIGNATURE <b>Walter R. Frantz, M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George, Cumberland, Md.</b>		ADDRESS	

## INSTRUCTIONS

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**2** **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

# CERTIFICATE OF DEATH

Reg. Dist. No.

1. Name of Deceased

2. Sex

3. Date of Birth

4. Place of Birth

5. Usual Residence

6. Date of Death

7. Time of Death

8. Cause of Death

9. Place of Death

10. Signature of Physician

11. Signature of Registrar

12. Signature of Coroner

13. Signature of Medical Examiner

14. Signature of Pathologist

15. Signature of Forensic Physician

16. Signature of Medical Director

17. Signature of Health Officer

18. Signature of Sanitary Officer

19. Signature of Registrar

20. Signature of Coroner

21. Signature of Medical Examiner

22. Signature of Pathologist

23. Signature of Forensic Physician

24. Signature of Medical Director

25. Signature of Health Officer

26. Signature of Sanitary Officer

27. Signature of Registrar

28. Signature of Coroner

29. Signature of Medical Examiner

30. Signature of Pathologist

31. Signature of Forensic Physician

32. Signature of Medical Director

33. Signature of Health Officer

34. Signature of Sanitary Officer

35. Signature of Registrar

36. Signature of Coroner

1. Name of Deceased

2. Sex

3. Date of Birth

4. Place of Birth

5. Usual Residence

6. Date of Death

7. Time of Death

8. Cause of Death

9. Place of Death

10. Signature of Physician

11. Signature of Registrar

12. Signature of Coroner

13. Signature of Medical Examiner

14. Signature of Pathologist

15. Signature of Forensic Physician

16. Signature of Medical Director

17. Signature of Health Officer

18. Signature of Sanitary Officer

19. Signature of Registrar

20. Signature of Coroner

21. Signature of Medical Examiner

22. Signature of Pathologist

23. Signature of Forensic Physician

24. Signature of Medical Director

25. Signature of Health Officer

26. Signature of Sanitary Officer

27. Signature of Registrar

28. Signature of Coroner

29. Signature of Medical Examiner

30. Signature of Pathologist

31. Signature of Forensic Physician

32. Signature of Medical Director

33. Signature of Health Officer

34. Signature of Sanitary Officer

35. Signature of Registrar

36. Signature of Coroner

NOTARY PUBLIC

I, \_\_\_\_\_, do hereby certify that the foregoing is a true and correct copy of the original Certificate of Death filed in my office on this \_\_\_\_\_ day of \_\_\_\_\_, 1955.

My Commission Expires \_\_\_\_\_

Notary Public for Maryland

RECEIVED

JUL 25 1955

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6149

06103

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 10

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
<u>X</u> TOWN <u>Mt. Savage</u>		<u>30 yrs.</u>		TOWN <u>Mt. Savage</u> <u>X</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location) <u>/</u>			
3. NAME OF DECEASED: (Type or Print)		(First) <u>Stephen</u>		(Middle) <u>S.</u>		(Last) <u>Boyle</u>	
5. SEX: <u>male</u>		6. COLOR OR RACE: <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>		8. DATE OF BIRTH: <u>June 25-1900</u>	
9. AGE last birthday: <u>55</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Train dispatcher</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>W.Md.R.Ry.</u>		11. BIRTHPLACE (State or foreign country): <u>Elkins, W. Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME: <u>Stephen Boyle</u>		14. MOTHER'S MAIDEN NAME: <u>Katie Donahue</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		(If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>705-10-7830</u>		17. INFORMANT & ADDRESS: <u>(wife) Mrs. S. Boyle, Mt. Savage, Md.</u>	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							sudden about 1 yr. 5 yrs.
(a) <u>2.60X</u> Immediate cause <u>Coronary occlusion</u> DUE TO							
(b) Antecedent cause(s) <u>Coronary sclerosis</u> DUE TO							
(c) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last <u>Diabetes Mellitus</u>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:							20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
19b. MAJOR FINDING OF OPERATION:							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town)		(County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE		H. V. Downing M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>Aug. 1-1955</u>	
DEPUTY MEDICAL EXAMINER		ASSISTANT MEDICAL EXAM.					
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>Aug. 3-1955</u>		NAME OF CEMETERY OR CREMATORY <u>St. Patricks</u>		LOCATION (City, town, or county) (State) <u>Mt. Savage, Md.</u>	
DATE REC'D BY LOCAL REG. <u>Aug. 2, 1955</u>		REGISTRAR'S SIGNATURE <u>Veronica Maden</u>		24. FUNERAL DIRECTOR <u>Joseph R. Durst</u>		ADDRESS <u>Frostburg, Md.</u>	

BUREAU V. S.

AUG 4 1965

RECEIVED

1. Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06104

6095

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH COUNTY <u>Allegany</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Allegany</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cumberland</u>		LENGTH OF STAY (in this place) <u>11 hours.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Mount Savage</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>62 Sacred Heart Hospital, City.</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print) (First) <u>Leo</u> (Middle) <u>Silvester</u> (Last) <u>Bridges, Jr.</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>July 31st, 19 55</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE/MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>May 5-55</u>	9. AGE last birthday <u>3 yrs.</u>	IF UNDER 1 YEAR Months <u>2</u> Days <u>26</u>	IF UNDER 24 HRS. Hours <u>26</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland Cumberland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Leo Bridges Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Olive Gordon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Leo Bridges Jr. Mt Savage Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
571.0 IMMEDIATE CAUSE (A) <u>Convulsions</u>						<u>24 hrs</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Eastro Enterick Acute</u>						<u>2 days</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>none</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <u>M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 29 19 55</u> to <u>July 31 19 55</u> , that I last saw the deceased alive on <u>July 31, 19 55</u> , and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>H. W. G. Murray M.D.</u>				ADDRESS (Street, city, town, state) <u>41 Green St Cumberland Md</u>		DATE SIGNED <u>Aug 1/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Aug 2, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>St Patrick's Cemetery</u>		LOCATION (City, town, or county) (State) <u>Mt Savage Allegany, Md</u>	
24. REC'D BY REGISTRAR <u>Aug. 1, 1955</u>		REGISTRAR'S SIGNATURE <u>Walter R. Frantz</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>M. L. Hargis</u>		ADDRESS <u>Hyndman Pa</u>	

105530633

105-101

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

# CERTIFICATE OF DEATH

0000

Reg. Dist. No.

LEGAL RESIDENCE (INDICATE OF DECEASED)

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

RELIGION

DATE

TIME

PLACE

TIME

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## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <b>Allegany</b>	MARYLAND	STATE <b>Maryland</b>	COUNTY <b>Allegany</b>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
02 TOWN <b>Cumberland</b>	12/19/52	TOWN <b>Frostburg</b>	22
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
91 <b>Allegany County Infirmary</b>		<b>104 W. Main Street.</b>	1
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <b>Jennie</b> (Middle) (Last) <b>Broadbeck</b>		(Month) (Day) (Year)	
		<b>July 7, 1955</b>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
<b>Female</b>	<b>White</b>	<b>Widow</b>	<b>3/28/65</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
<b>Housewife</b>		<b>Own Home</b>	<b>Maryland</b>
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<b>John Keirs</b>		<b>Janet Morton</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<b>No</b>		<b>None</b>	
17. INFORMANT & ADDRESS		18. MEDICAL CERTIFICATION	
<b>Allegany County Infirmary Records</b>		I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	
		331X IMMEDIATE CAUSE (A) <b>Cerebral Thrombosis</b>	
		ANTECEDENT CAUSE(S) DUE TO (B) <b>Chronic Myocarditis</b>	
		DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <b>Cerebral arteriosclerosis</b>	
		<b>Senile Deterioration</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		INTERVAL BETWEEN ONSET AND DEATH	
		<b>72 hrs.</b>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
22. I hereby certify that I attended the deceased from <b>Feb. 14, 1955</b> to <b>July 7, 1955</b> , that I last saw the deceased alive on <b>July 7, 1955</b> , and that death occurred at <b>11:55 P.M.</b> from the causes and on the date stated above.			
SIGNATURE		ADDRESS (Street, city, town, state)	
<b>James B. McLean M.D.</b>		<b>49 Greene St.</b>	
DATE SIGNED			
<b>7-8-55</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<b>Burial</b>	<b>7-10-55</b>	<b>F'bg. Memorial Park</b>	<b>Frostburg, Md.</b>
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
<b>July 12, 1955</b>	<b>Walter R. Frank, M.D.</b>	<b>Joseph R. Durst,</b>	<b>Frostburg, Md.</b>

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

# CERTIFICATE OF DEATH

OF WHITE PERSONS (FORM OF DECEMBER 1943)

OF COLOR PERSONS (FORM OF DECEMBER 1943)

NAME OF DECEASED  
 SEX  
 AGE  
 DATE OF BIRTH  
 PLACE OF BIRTH  
 OCCUPATION  
 CAUSE OF DEATH  
 PLACE OF DEATH  
 DATE OF DEATH

NAME OF DECEASED  
 SEX  
 AGE  
 DATE OF BIRTH  
 PLACE OF BIRTH  
 OCCUPATION  
 CAUSE OF DEATH  
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 DIVISION OF VITAL STATISTICS  
 BALTIMORE, MARYLAND  
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**1. TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**2. TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

DR R J WMS.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## CERTIFICATE OF DEATH

06106

Reg. Dist. No. 4

6097

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>ALLEGANY</b>		STATE <b>MARYLAND</b>		COUNTY <b>Allegany</b>			
CITY (If outside corporate limits, write RURAL and give nearest town) <b>02 CUMBERLAND</b>		LENGTH OF STAY (in this place) <b>ONE DAY</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND, Rural</b>		<b>X</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>60 MEMORIAL HOSPITAL</b>				STREET ADDRESS (If rural give location) <b>EASTMAN ROAD - P.O. Box 55</b>			
<b>3. NAME OF DECEASED</b> (First) <b>ALFRED</b> (Middle) <b>BROADWATER</b> (Last)				<b>4. DATE OF DEATH</b> (Month) <b>JULY</b> (Day) <b>15</b> (Year) <b>19 55</b>			
<b>5. SEX</b> <b>MALE</b>	<b>6. COLOR OR RACE</b> <b>WHITE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>WIDOWED</b>	<b>8. DATE OF BIRTH</b> <b>OCT 20 1875</b>	<b>9. AGE last birthday</b> <b>79 yrs.</b>	<b>IF UNDER 1 YEAR</b> Months Days	<b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Land Surveyor Self Employed</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>SOMERSET CO. PA.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A</b>	
<b>13. FATHER'S NAME</b> <b>CHARLES BROADWATER</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Unknown</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>40</b>		<b>16. SOCIAL SECURITY NO.</b> <b>214-34-1204</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Clarence Broadwater-Eastman Rd</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>420.1 IMMEDIATE CAUSE (A)</b> <b>Coronary Thrombosis</b>						<b>24 hrs</b>	
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <b>Coronary Atherosclerosis</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b>							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work</b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from 7/17/55, 19 to 7/15/55, 19, that I last saw the deceased alive on 7/14/55, 19, and that death occurred at 2:35 P.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>[Signature]</i>		<b>M. D.</b> <i>[Signature]</i>		<b>ADDRESS (Street, city, town, state)</b> <i>Cumberland Pa</i>		<b>DATE SIGNED</b> <i>7/15/55</i>	
<b>23. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>7/17/55</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>mt Lebanon Cemetery</b>		<b>LOCATION (City, town, or county) (State)</b> <b>Glencoe Pa</b>	
<b>24. REC'D BY REGISTRAR</b> <b>DATE</b> <i>July 16, 1955</i>		<b>REGISTRAR'S SIGNATURE</b> <i>Walter R. Franz, M.D.</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>John F. Hager</i>		<b>ADDRESS</b> <i>Cumberland Pa</i>	

# CERTIFICATE OF DEATH

6033

Reg. Dist. No.

1. Medical Record (To be filled out by physician)

2. Place of Death

3. Cause of Death

4. Date of Death

5. Name of Deceased

6. Sex

7. Age

8. Race

9. Marital Status

10. Occupation

11. Date of Birth

12. Place of Birth

13. Date of Admission

14. Date of Discharge

15. Date of Death

16. Date of Death

17. Date of Death

18. Date of Death

*Handwritten signature and notes*

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06107

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## CERTIFICATE OF DEATH

Reg. Dist. No. 6

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Allegany</u>		STATE <u>Md.</u>		COUNTY <u>Allegany</u>			
CITY OR TOWN <u>Westernport</u>		CITY OR TOWN <u>Westernport</u>		CITY OR TOWN <u>Westernport</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>420 Maryland Ave.</u>		HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>420 Maryland Ave.</u>		HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>420 Maryland Ave.</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Elizabeth Charlott Burns</u>				<b>4. DATE OF DEATH</b> (Month) <u>July</u> (Day) <u>12</u> (Year) <u>1955</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>Sept. 28, 1875</u>	
9. AGE last birthday <u>79</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House-wife</u>		11. BIRTHPLACE (State or foreign country) <u>Brumpton, Canada.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Studd</u>				14. MOTHER'S MAIDEN NAME <u>Johanna Callahan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT & ADDRESS <u>Leonora Burns, Westernport, Md.</u>							
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
151X IMMEDIATE CAUSE (A) <u>Carcinoma of Stomach.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>10 Mo.</u>			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) <u></u>							
DUE TO (C) <u></u>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 10, 1955</u> to <u>July 12, 1955</u> , that I last saw the deceased alive on <u>July 12, 1955</u> , and that death occurred at <u>11:45 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Robert W. Bass</u>				DATE SIGNED <u>7/13/55</u>			
ADDRESS <u>Piedmont, WVa.</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE WHEREOF <u>8-15-55</u>		NAME OF CEMETERY OR CREMATORY <u>St. Peters Cemetery</u>		LOCATION (City, town, or county) (State) <u>Westernport, Md</u>	
24. REC'D BY REGISTRAR <u>7-15-55</u>		REGISTRAR'S SIGNATURE <u>Mrs Jean C Kelly</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W.H. Fiddlock Jr</u>		ADDRESS <u>Piedmont, W.Va.</u>	

# CERTIFICATE OF DEATH

611

Reg. Dist. No.

1. Usual Residence (Date of Death)

65. 1000 N. E. Street

BALTIMORE

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06108

Reg. Dist.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 4

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Allegheny</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Allegheny</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Cumberland</u>	LENGTH OF STAY (in this place) <u>3.1/2 hrs.</u>	CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Cumberland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sacred Heart Hospital</u>		STREET ADDRESS (If rural, give location) <u>441 N.Center St.</u>	
3. NAME OF DECEASED: (Type or Print)	(First) <u>Edith</u>	(Middle) <u>Thelma</u>	(Last) <u>Cessna</u>
4. DATE OF DEATH	(Month) <u>July</u>	(Day) <u>25</u>	(Year) <u>19 55</u>
5. SEX: <u>female</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH: <u>Dec. 27-1904</u>
9. AGE last birthday: <u>50</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY: <u>Own Home</u>	11. BIRTHPLACE (State or foreign country): <u>Cumberland, Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	13. FATHER'S NAME: <u>John T. Bucy</u>	14. MOTHER'S MAIDEN NAME: <u>Ida Catherine Marvin</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>	(If Yes, give war or dates of service)	16. SOCIAL SECURITY No.: <u>none</u>	17. INFORMANT & ADDRESS: <u>441 N.Center St. Mrs. William Rixer, Cumberland, Md.</u>

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
(a) <u>Exsanguination</u>		<u>about 6 hours.</u>
Immediate cause DUE TO		
(b) <u>rupture of esophageal varices</u>		
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last		
(c) <u>Cirrhosis of the liver.</u>		<u>?</u>

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE H.V. Deming M.D. H.V. Deming M.D. M. D. CHIEF MEDICAL EXAMINER ☐ DATE SIGNED July 26-1955  
DEPUTY MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAM. ☐

23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF <u>7-29-55</u>	NAME OF CEMETERY OR CREMATORY <u>Hillcrest Cem.</u>	LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>
DATE REC'D BY LOCAL REG. <u>July 27, 1955</u>	REGISTRAR'S SIGNATURE <u>Winters R. Frank, M.D.</u>	24. FUNERAL DIRECTOR <u>Chas. L. George - Cumberland, Md.</u>	ADDRESS <u>George</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU Y. B.

JUL 29 1955

RECEIVED

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

6142

## CERTIFICATE OF DEATH

06109

Reg. Dist. No. 9

Item 14, Film G183 8/3/55L

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		STATE <u>MARYLAND</u>		STATE <u>Rhode Island</u>		COUNTY <u>Providence</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>22 Frostburg</u>		LENGTH OF STAY (in this place) <u>11 mos.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Woonsocket</u>		<u>76 x-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>119 Maple St.</u>				STREET ADDRESS (If rural give location) <u>286 Park Place</u>			
3. NAME OF DECEASED (Type or Print) <u>ALBERT F. CLARK, SR.</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>July 17, 1955</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Nov. 20, 1881</u>	9. AGE last birthday <u>73</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Rayon mills</u>		11. BIRTHPLACE (State or foreign country) <u>Rhode Island</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Willis A. Clark</u>				14. MOTHER'S MAIDEN NAME <u>Ida L. Stevens Stearns</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>036-05-5908A</u>		17. INFORMANT & ADDRESS <u>Mrs. Rudolph Winkler, Frostburg, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>CEREBRAL HEMORRHAGE</u>						<u>4 1/2 HRS.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>HYPERTENSIVE HEART DISEASE</u>						<u>YEARS</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>ARTERIOSCLEROSIS CARDIO VASCULAR</u>						<u>YEARS</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>✓</u>		19b. MAJOR FINDINGS OF OPERATION <u>✓</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>✓</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>✓</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) <u>✓</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>✓</u>			
22. I hereby certify that I attended the deceased from <u>APRIL 1954</u> to <u>JULY 17, 1955</u> , that I last saw the deceased alive on <u>7/17, 1955</u> , and that death occurred at <u>4:25 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Martin Brothstein M.D.</u>		ADDRESS (Street, city, town, state) <u>45 Broadway, Frostburg, Md.</u>		DATE SIGNED <u>7/18/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>7-19-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Frostburg Memorial Park</u>		LOCATION (City, town, or county) (State) <u>Frostburg, Md.</u>	
24. REC'D BY REGISTRAR <u>7-19-55 Mrs. Nancy A. Rice</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. R. Durst</u>		ADDRESS <u>Frostburg, Md.</u>	

BUREAU V.

107 25 1955

RECEIVED

06110

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

6799

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>allegany</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>allegany</u>	
CITY (If outside corporate limits, write RURAL OR end give nearest town) <u>02 Cumberland</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL end give nearest town) <u>02 Cumberland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00 40 Humbird St</u>				STREET ADDRESS (If rural give location) <u>40 Humbird St.</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>John Robert Darnley</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>July 22 19 55</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Dec 23, 1889</u>	9. AGE last birthday <u>67</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bellevue Worker Belvedere Corp</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Sonacorning Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>James Darnley</u>				14. MOTHER'S MAIDEN NAME <u>Edith Galbraith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>220-10-2577</u>		17. INFORMANT'S ADDRESS <u>Edith Darnley - 40 Humbird St.</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
422.1 IMMEDIATE CAUSE (A) <u>Cerebral Vascular Accident</u>						2 Day	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Cerebral Vascular Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>SBilateral Pneumonitis</u>						3 Day	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)				21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>11/1</u> , 19 <u>54</u> , to <u>July</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>7/22</u> , 19 <u>55</u> , and that death occurred at <u>7:10 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>William L. Brantz, M.D.</u>				ADDRESS (Street, city, town, state) <u>133 Va Ave Cumberland Md</u>			
DATE SIGNED <u>7/24/55</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>July 25, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>		LOCATION (City, town, or county) (State) <u>Meyersdale Pa</u>	
24. REC'D BY REGISTRAR <u>July 25, 1955</u>		REGISTRAR'S SIGNATURE <u>Walter R. Brantz, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer</u>		ADDRESS <u>Cumberland Md</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

# CERTIFICATE OF DEATH

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DATE OF DEATH

PLACE HERE NAME OF DECEASED

PLACE HERE  
NAME OF THE  
DECEASED

BUREAU V. 2

JUL 26 1955

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RECEIVED

RECEIVED  
MASSACHUSETTS DEPARTMENT OF HEALTH  
BALTIMORE, MD.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6150

061111

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 8

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Allegany</u>		MARYLAND	STATE <u>MD.</u>		COUNTY <u>Allegany</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town)		
<u>TOWN Midland</u>		<u>15 yrs.</u>	<u>TOWN Midland</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS			STREET ADDRESS (If rural, give location)		
<u>Paridice St.</u>			<u>Paridice St.</u>		
3. NAME OF DECEASED:			4. DATE OF DEATH		
(First) (Middle) (Last)			(Month) (Day) (Year)		
<u>Harold Dyson Davis</u>			<u>July 11 19 55</u>		
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:		9. AGE last birthday:
<u>male</u>	<u>white</u>	<u>married</u>	<u>July 7-1911</u>		<u>44</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, (then if retired))		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<u>Clerk-foot room</u>		<u>Kelley-S. Tire Co.</u>		<u>Charlotte Hall, Md.</u>	
13. FATHER'S NAME:			14. MOTHER'S MAIDEN NAME:		
<u>John M. Davis</u>			<u>Nettie Dyson</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:
<u>Yes-Navy W.W.2</u>			<u>678-10-6455</u>		<u>(wife) Agnes Manley Davis, Midland, Md.</u>

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				Sudden	
976x Immediate cause (a) <u>Intracranial hemorrhage due to a 22 (short)</u> DUE TO Antecedent cause(s) (b) <u>rifle (Stevens automatic) bullet in right</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c) <u>temporal region, self inflicted.</u>					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Despondent.</u>					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc.)		21c. (City or town) (County) (State)	
<u>Self inflicted</u>		<u>Home</u>		<u>Midland Allegany Md.</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>July 11-1955 P.M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Self inflicted rifle bullet in right temporal region.</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE					
<u>H. V. Deming M.D.</u>					
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>		<u>July 14, 1955</u>		<u>St. Michael Cemetery</u>	
DATE REC'D BY LOCAL REG		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS	
<u>7-14-55</u>		<u>Janette M. Gool</u>		<u>George Eichhorn, Lonaconing, MD.</u>	

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JUL 20 1955

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UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

1. **INSTRUCTIONS**  
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

06112

Reg. Dist. No. 4

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Allegany</u>	MARYLAND	STATE <u>Ind</u>	COUNTY <u>Allegany</u>
CITY OR TOWN <u>02 Cumberland</u>	LENGTH OF STAY (in this place)	CITY OR TOWN <u>Cumberland 02</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00 629 Bedford St.</u>		STREET ADDRESS <u>629 Bedford St.</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>Floyd Maurice DeVore</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>July 12 1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 12, 1896</u>
9. AGE last birthday <u>59</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Postal Clerk Post Office</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Ellerslie, Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>John S. DeVore</u>		14. MOTHER'S MAIDEN NAME <u>Ellie Cook</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>yes</u> (If Yes, give war or dates of service) <u>World War</u>		16. SOCIAL SECURITY NO. <u>214-32-3629</u>	
17. INFORMANT & ADDRESS <u>Ralph DeVore-Ellerslie Ind.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
163X IMMEDIATE CAUSE (A) <u>Carcinoma of lung</u>		INTERVAL BETWEEN ONSET AND DEATH <u>First seen 4.9.55</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Metastasis to brain</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4-9-1955</u> to <u>7-12-1955</u> , that I last saw the deceased alive on <u>7-11-1955</u> , and that death occurred at <u>3:15 PM</u> , from the causes and on the date stated above.			
SIGNATURE <u>Wm. S. Williams, M.D.</u>		ADDRESS (Street, city, town, state) <u>Cumberland</u>	
DATE SIGNED <u>7-13-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>July 14, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cem.</u>		LOCATION (City, town, or county) <u>Cumberland, Ind.</u>	
24. REC'D BY REGISTRAR <u>July 14, 1955</u>		REGISTRAR'S SIGNATURE <u>White R. Frantz, M.D.</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer</u>		ADDRESS <u>Cumberland Ind.</u>	

1915

# CERTIFICATE OF DEATH

REG. GEN. NO.

DATE OF DEATH

PLACE OF DEATH

DECEASED

SEX

AGE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

MARRIAGE

PREVIOUS MARRIAGES

CAUSE OF DEATH

IMMEDIATE CAUSE

INTERMEDIATE CAUSE

PREEXISTING DISEASE

PERIOD OF ILLNESS

PERIOD OF INCUBATION

PERIOD OF LATENCY

PERIOD OF REMISSION

PERIOD OF PROGRESSION

PERIOD OF TERMINATION

PERIOD OF RECOVERY

PERIOD OF STABILIZATION

PERIOD OF REMISSION

PERIOD OF PROGRESSION

PERIOD OF TERMINATION

PERIOD OF RECOVERY

PERIOD OF STABILIZATION

PERIOD OF REMISSION

PERIOD OF PROGRESSION

PERIOD OF TERMINATION

REGISTERED

AMERICAN STATE DEPARTMENT OF HEALTH

BUREAU OF VITAL STATISTICS

1915

Outside of  
City Limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06113

6151 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Allegany</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Allegany</b>	
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) <b>X</b> <b>LaVale</b>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL OR TOWN) <b>LaVale</b>		<b>X</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>00 R#1, Box 293-Cumberland</b>				STREET ADDRESS (If rural give location) <b>R#1, Box 293-Cumberland</b>			
3. NAME OF DECEASED: (First) <b>William</b> (Middle) <b>Richard</b> (Last) <b>Dowlan</b>				4. DATE OF DEATH: (Month) <b>July</b> (Day) <b>18</b> (Year) <b>1955</b>			
5. SEX: <b>Male</b>		6. COLOR OR RACE: <b>White</b>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>Married</b>		8. DATE OF BIRTH: <b>Jan. 26, 1891</b>	
9. AGE last birthday: <b>64</b> yrs.		10. MONTHS: <b>5</b>		11. DAYS: <b>22</b>		12. HOURS: <b>19</b>	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <b>Storeroom Dept. B. &amp; O. R.R. Co.</b>				11. BIRTHPLACE (State or foreign country): <b>Martinsburg, W. Va.</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME: <b>James S. Dowlan</b>			
14. MOTHER'S MAIDEN NAME: <b>Mary Bateman</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>no</b> (If Yes, give war or dates of service)			
16. SOCIAL SECURITY No.: <b>220-10-8881</b>				17. INFORMANT & ADDRESS: <b>Lillie C. Dowlan R. I. Cumberland</b>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				Interval Between Onset And Death			
420.1 Immediate cause (a) <b>Coronary Thrombosis</b>				<b>2 from</b>			
Antecedent causes (s) (b) <b>Coronary Arteriosclerosis</b>				<b>1 yr.</b>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) <b>hypertension</b>							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>schizoid</b>							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>June 20, 1955</b> to <b>July 18, 1955</b> , that I last saw the deceased alive on <b>July 18, 1955</b> , and that death occurred at <b>5:45 A.M.</b> from the causes and on the date stated above.							
SIGNATURE <b>R. R. Brown, M.D. - Fort Cobb, W.Va.</b>				DATE SIGNED <b>7/17/55</b>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>7-21-55</b>		<b>Abe Cemetery</b>		<b>Mineral County, W. Va.</b>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<b>July 21, 1955</b>		<b>Walter R. Frantz, M.D.</b>		<b>Rogers Funeral Home</b>		<b>Keyser, W. Va.</b>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 3

JUL 22 1955

RECEIVED

**1** **TO ATTENDING PHYSICIAN:** The law requires that the death certificate be retained by the hospital or attending physician. The bottom copy may be retained by the hospital or attending physician.

**2** **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06114

6101

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>ALLEGANY</b>		STATE <b>MARYLAND</b>		COUNTY <b>ALLEGANY</b>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>02 CUMBERLAND</b>		LENGTH OF STAY (In this place) <b>11 DAYS</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>02 CUMBERLAND</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>60 MEMORIAL HOSPITAL MEMORIAL &amp; WARWICK AVES.,</b>				STREET ADDRESS (If rural give location) <b>18 SANDRINGHAM ROAD</b>		<b>02</b>	
<b>3. NAME OF DECEASED</b> (Type or Print) (First) (Middle) (Last) <b>MARY AGNES DYCHE</b>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>JULY 8 19 55</b>			
<b>5. SEX</b> <b>FEMALE</b>	<b>6. COLOR OR RACE</b> <b>WHITE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)</b> <b>MARRIED</b>	<b>8. DATE OF BIRTH</b> <b>AUG. 24 1885</b>	<b>9. AGE last birthday</b> <b>69</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days	<b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Own home</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>MT. SAVAGE, MARYLAND</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>TIMOTHY CROWLEY</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>MARY MULLANEY</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>None</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Mr. Wm. Dyche, Cumberland, Md.</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>443X</b> IMMEDIATE CAUSE (A) <b>Cerebral Thrombosis</b>						<b>One wk.</b>	
ANTECEDENT CAUSE(S) DUE TO (B) <b>Chronic Hypertensive Arterio</b>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <b>Sclerotic Vascular Dis.</b>							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE</b> (Home, farm, factory, OF INJURY street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21a. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from 6-6-55 to 7-8-55 that I last saw the deceased alive on 7-7-55, and that death occurred at 7:20AM from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <b>W.A. Williams</b> M.D.				<b>ADDRESS</b> (Street, city, town, state) <b>Cumberland</b>		<b>DATE SIGNED</b> <b>7-8-55</b>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>July 11, 1955</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>St. Patricks Cemetery</b>		<b>LOCATION</b> (City, town, or county) (State) <b>Cumberland, Md.</b>	
<b>24. REC'D BY REGISTRAR</b> <b>July 10, 1955</b>		<b>REGISTRAR'S SIGNATURE</b> <b>Winters R. Frank, M.D.</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Charles L. George, Cumberland, Md.</b>		<b>ADDRESS</b>	

RECEIVED

RECEIVED  
 DIVISION OF INVESTIGATION  
 U. S. DEPARTMENT OF JUSTICE  
 WASHINGTON, D. C.  
 JUL 12 1955

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 19

DATE OF DEATH

1. PLACE OF DEATH

2. NAME OF DECEASED  
 MARY ANN  
 3. SEX  
 FEMALE  
 4. AGE  
 11 DAYS  
 5. RACE  
 WHITE  
 6. MARITAL STATUS  
 SINGLE

7. OCCUPATION  
 8. PLACE OF BIRTH  
 9. DATE OF BIRTH  
 10. PLACE OF DEATH  
 11. DATE OF DEATH  
 12. TIME OF DEATH

13. CAUSE OF DEATH  
 14. MANNER OF DEATH  
 15. MEDICAL CERTIFICATION

16. SIGNATURE OF DECEASED  
 17. SIGNATURE OF WITNESSES  
 18. SIGNATURE OF PHYSICIAN

19. SIGNATURE OF REGISTRAR  
 20. SIGNATURE OF CLERK

21. SIGNATURE OF DECEASED  
 22. SIGNATURE OF WITNESSES  
 23. SIGNATURE OF PHYSICIAN

24. SIGNATURE OF REGISTRAR  
 25. SIGNATURE OF CLERK

26. SIGNATURE OF DECEASED  
 27. SIGNATURE OF WITNESSES  
 28. SIGNATURE OF PHYSICIAN

29. SIGNATURE OF REGISTRAR  
 30. SIGNATURE OF CLERK

31. SIGNATURE OF DECEASED  
 32. SIGNATURE OF WITNESSES  
 33. SIGNATURE OF PHYSICIAN

34. SIGNATURE OF REGISTRAR  
 35. SIGNATURE OF CLERK

36. SIGNATURE OF DECEASED  
 37. SIGNATURE OF WITNESSES  
 38. SIGNATURE OF PHYSICIAN

39. SIGNATURE OF REGISTRAR  
 40. SIGNATURE OF CLERK

41. SIGNATURE OF DECEASED  
 42. SIGNATURE OF WITNESSES  
 43. SIGNATURE OF PHYSICIAN

44. SIGNATURE OF REGISTRAR  
 45. SIGNATURE OF CLERK

46. SIGNATURE OF DECEASED  
 47. SIGNATURE OF WITNESSES  
 48. SIGNATURE OF PHYSICIAN

BUREAU V. 1

JUL 12 1955

RECEIVED

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06115

6143

## CERTIFICATE OF DEATH

Reg. Dist. No. 9

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Allegany</u>		STATE <u>Maryland</u> COUNTY <u>Allegany</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>	
CITY OR TOWN <u>22 Frostburg</u>		LENGTH OF STAY (in this place) <u>1 night</u>		STREET ADDRESS (If rural give location) <u>220 W. Mechanic St.</u>		STREET ADDRESS <u>220 W. Mechanic St.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>61 Miners Hospital</u>				STREET ADDRESS (If rural give location) <u>220 W. Mechanic St.</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>EVELYN H. ELLIOTT</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>July 27, 19 55</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Jan. 14, 1913</u>	9. AGE last birthday <u>42</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Lonaconing, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Chas. Cuthbertson</u>				14. MOTHER'S MAIDEN NAME <u>Marian Isat</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>(If Yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>214-07-3798</u>		17. INFORMANT & ADDRESS <u>George Elliott, Frostburg, Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
274X IMMEDIATE CAUSE (A) <u>ADDISON'S DISEASE !!</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 moe ???</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <input checked="" type="checkbox"/>							
19a. DATE OF OPERATION <input checked="" type="checkbox"/>		19b. MAJOR FINDINGS OF OPERATION <input checked="" type="checkbox"/>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <input checked="" type="checkbox"/>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <input checked="" type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <input checked="" type="checkbox"/>			
22. I hereby certify that I attended the deceased from <u>7/26</u> , 19 <u>55</u> , to <u>7/27</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>7/27</u> , 19 <u>55</u> , and that death occurred at <u>7:45 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Marjorie D. Durst, M.D. 48 Broadway - Frostburg, Md. 7/27/55</u>				ADDRESS (Street, city, town, state) <u>48 Broadway - Frostburg, Md.</u> DATE SIGNED <u>7/27/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>7-29-55</u>		NAME OF CEMETERY OR CREMATORY <u>Methodist Cemetery</u>		LOCATION (City, town, or county) (State) <u>Mt. Savage, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>7-29-55</u>		REGISTRAR'S SIGNATURE <u>Marjorie D. Durst</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. R. Durst,</u>		ADDRESS <u>Frostburg, Md.</u>	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6102  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. 06116

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY	Allegany		STATE	Md.	
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town)		
TOWN	Cumberland		TOWN (rural)	Mt. Savage	
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Dead on arrival at the Sacred Heart Hospital		STREET ADDRESS	(If rural, give location)	
			Route #1		
3. NAME OF DECEASED:			4. DATE OF DEATH		
(First)	(Middle)	(Last)	(Month)	(Day)	(Year)
Norma	Jean	Gillespie	July	3	19 55
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR IF UNDER 24 HRS.
female	white	single	April 11-1932	23 yrs.	Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, or at time of death)			10b. KIND OF BUSINESS OR INDUSTRY:		
beautician			Hair dresser		
11. BIRTHPLACE (State or foreign country):			12. CITIZEN OF WHAT COUNTRY?		
Cumberland, Md.			U.S.A.		
13. FATHER'S NAME:			14. MOTHER'S MAIDEN NAME:		
James Gillespie			Katherine Rankin		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY No.:		
no			220-28-7517		
17. INFORMANT & ADDRESS:			(father) James Gillespie		

18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			
812X Immediate cause (a) Intra-abdominal hemorrhage due to ruptured spleen, Retroperitoneal hemorrhage (massive) due to complete transverse fracture of the 2nd. & 3rd. lumbar vertebrae. Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) Hit by an automobile, walking on highway.			about 20 Min.
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:			20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>	21b. PLACE (Home, farm, factory, OF street, office, pdg., etc., INJURY at #36)	21c. (City or town) (County) (State)	
	(near) Mt. Savage	Allegany Md.	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY July 3-1955 A.M.	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? Walking on highway hit by an automobile.	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE			
H. V. Deming M.D. H. V. Deming M.D. M. D. CHIEF MEDICAL EXAMINER			
DEPUTY MEDICAL EXAMINER			
ASSISTANT MEDICAL EXAM. * July 3-1955			
23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	July 6, 1955	St. Patrick's Church	Mt. Savage, Maryland
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
July 5, 1955	Walter R. Grant, M.D.	Harvey A. Zeigler, Kynardus, Pa.	

RECEIVED

JUL 7 1955

BUREAU V. S.

06117

6103

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH

COUNTY

Allegany

MARYLAND

CITY (If outside corporate limits, write RURAL  
OR and give nearest town)

02

TOWN

Cumberland

LENGTH OF STAY  
(in this place)

4/3/54

HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS

91

Allegany County Infirmary

## 2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland

COUNTY Allegany

CITY (If outside corporate limits, write RURAL and give nearest town)

OR

TOWN Frostburg

22

STREET ADDRESS 125 E. Main St.

1

3. NAME OF  
DECEASED  
(Type or Print)

(First)

Margaret

(Middle)

A.

(Last)

Goodwin

4. DATE  
OF  
DEATH

(Month)

July 6,

(Day)

1955

## 5. SEX

Female

6. COLOR OR  
RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify) Widow

## 8. DATE OF BIRTH

11/24/1889

## 9. AGE last birthday

65

yrs.

## IF UNDER 1 YEAR

Months

Days

## IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if  
retired) Housewife10b. KIND OF BUSINESS  
OR INDUSTRY

Own Home

## 11. BIRTHPLACE (State or foreign country)

New York

12. CITIZEN OF WHAT  
COUNTRY?

U. S. A.

## 13. FATHER'S NAME

Andrew C. Steinert

## 14. MOTHER'S MAIDEN NAME

Mary Ann Coffee

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unk.) (If Yes, give war or dates of service)

No

## 16. SOCIAL SECURITY NO.

213-05-7140D

## 17. INFORMANT &amp; ADDRESS

Allegany County Infirmary Records

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1

## IMMEDIATE CAUSE

(A)

## ANTECEDENT CAUSE(S)

DUE TO

DISEASES OR CONDITIONS, IF ANY,  
GIVING RISE TO THE ABOVE CAUSE  
STATING UNDERLYING CAUSE LAST.

(B)

DUE TO

(C)

11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.

## 18. MEDICAL CERTIFICATION

Coronary sclerosis -

Chronic Hypertension

General arteriosclerosis

Obesity -

INTERVAL BETWEEN  
ONSET AND DEATH

Sudden

?

?

?

?

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,  
OF INJURY street, office bldg., etc.)

## 21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

## 21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

## 21e. INJURY OCCURRED

While

at work ☐

Not while

at work ☐

## 21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 3, 1954, to July 6, 1955, that I last saw the deceased alive on July 5, 1955, and that death occurred at 6:30 A.M. from the causes and on the date stated above.

## SIGNATURE

Joseph R. Durst, M.D.

## ADDRESS (Street, city, town, state)

49 Greene St.

## DATE SIGNED

7-6-55

23. BURIAL, CREMATION,  
REMOVAL (SPECIFY)

Burial

## DATE THEREOF

7-8-55

## NAME OF CEMETERY OR CREMATORY

St. Michael's Cemetery

## LOCATION (City, town, or county)

Frostburg,

## (State)

Md.

## 24. REC'D BY REGISTRAR

## REGISTRAR'S SIGNATURE

Walter R. Frank, M.D.

## 25. FUNERAL DIRECTOR'S SIGNATURE

Joseph R. Durst,

## ADDRESS

Frostburg, Md.

INSTRUCTIONS

**1. TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**2. TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

# CERTIFICATE OF DEATH

Reg. Dist. No.

1. DEATH INFORMATION FROM THE REGISTRAR

NAME OF DECEASED: **ALLEN, JAMES**  
 PLACE OF BIRTH: **ALLEN, JAMES**  
 DATE OF BIRTH: **1901**  
 SEX: **MALE**  
 RACE: **WHITE**  
 OCCUPATION: **LABORER**

DATE OF DEATH: **1955**  
 PLACE OF DEATH: **ALLEN, JAMES**  
 CAUSE OF DEATH: **HEART DISEASE**  
 MANNER OF DEATH: **NATURAL**

2. DEATH INFORMATION FROM THE REGISTRAR

NAME OF DECEASED: **ALLEN, JAMES**  
 PLACE OF BIRTH: **ALLEN, JAMES**  
 DATE OF BIRTH: **1901**  
 SEX: **MALE**  
 RACE: **WHITE**  
 OCCUPATION: **LABORER**

DATE OF DEATH: **1955**  
 PLACE OF DEATH: **ALLEN, JAMES**  
 CAUSE OF DEATH: **HEART DISEASE**  
 MANNER OF DEATH: **NATURAL**

3. DEATH INFORMATION FROM THE REGISTRAR

NAME OF DECEASED: **ALLEN, JAMES**  
 PLACE OF BIRTH: **ALLEN, JAMES**  
 DATE OF BIRTH: **1901**  
 SEX: **MALE**  
 RACE: **WHITE**  
 OCCUPATION: **LABORER**

DATE OF DEATH: **1955**  
 PLACE OF DEATH: **ALLEN, JAMES**  
 CAUSE OF DEATH: **HEART DISEASE**  
 MANNER OF DEATH: **NATURAL**

4. DEATH INFORMATION FROM THE REGISTRAR

NAME OF DECEASED: **ALLEN, JAMES**  
 PLACE OF BIRTH: **ALLEN, JAMES**  
 DATE OF BIRTH: **1901**  
 SEX: **MALE**  
 RACE: **WHITE**  
 OCCUPATION: **LABORER**

DATE OF DEATH: **1955**  
 PLACE OF DEATH: **ALLEN, JAMES**  
 CAUSE OF DEATH: **HEART DISEASE**  
 MANNER OF DEATH: **NATURAL**

5. DEATH INFORMATION FROM THE REGISTRAR

NAME OF DECEASED: **ALLEN, JAMES**  
 PLACE OF BIRTH: **ALLEN, JAMES**  
 DATE OF BIRTH: **1901**  
 SEX: **MALE**  
 RACE: **WHITE**  
 OCCUPATION: **LABORER**

DATE OF DEATH: **1955**  
 PLACE OF DEATH: **ALLEN, JAMES**  
 CAUSE OF DEATH: **HEART DISEASE**  
 MANNER OF DEATH: **NATURAL**

6. DEATH INFORMATION FROM THE REGISTRAR

NAME OF DECEASED: **ALLEN, JAMES**  
 PLACE OF BIRTH: **ALLEN, JAMES**  
 DATE OF BIRTH: **1901**  
 SEX: **MALE**  
 RACE: **WHITE**  
 OCCUPATION: **LABORER**

DATE OF DEATH: **1955**  
 PLACE OF DEATH: **ALLEN, JAMES**  
 CAUSE OF DEATH: **HEART DISEASE**  
 MANNER OF DEATH: **NATURAL**

BUREAU V. B.

JUL 12 1955

RECEIVED

RECEIVED

When corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06118

6104

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cumberland</u>		<u>Life</u>		TOWN <u>Cumberland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>443 Henderson Ave</u>				STREET ADDRESS (If rural give location) <u>443 Henderson Ave</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>Minnie L Hart</u>				<u>July 18 19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Single</u>	<u>Nov. 1, 1870</u>	<u>84</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>None</u>				<u>Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME <u>John W Hart</u>				14. MOTHER'S MAIDEN NAME <u>Christina Stark</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>NO</u>		<u>None</u>		<u>Miss Anna Hart Cumberland, Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
334X IMMEDIATE CAUSE (A) <u>Arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cerebral Sclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				2D. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/23</u> , 19 <u>53</u> , to <u>7/18</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>7/17</u> , 19 <u>55</u> , and that death occurred at <u>456 N. Centre St.</u> , M, from the causes and on the date stated above.							
SIGNATURE <u>Lee W. Lenz Jr.</u>		M.D. <u>456 N. Centre St.</u>		DATE SIGNED <u>7/20/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>7,20,1955</u>		<u>St. lukes Cemetery</u>		<u>Cumberland Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>July 20, 1955</u>		<u>Walter R. Frank, M.D.</u>		<u>Louis Stein, Inc.</u>		<u>Cumberland, Md.</u>	

# CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. RACE White		5. BIRTH DATE May 1, 1920		6. BIRTH PLACE Jackson, Mississippi	
7. DECEASED DATE April 4, 1968		8. DECEASED TIME 2:01 PM		9. DECEASED PLACE Memphis, Tennessee	
10. DECEASED TIME 2:01 PM		11. DECEASED PLACE Memphis, Tennessee		12. DECEASED TIME 2:01 PM	
13. DECEASED PLACE Memphis, Tennessee		14. DECEASED TIME 2:01 PM		15. DECEASED PLACE Memphis, Tennessee	
16. DECEASED TIME 2:01 PM		17. DECEASED PLACE Memphis, Tennessee		18. DECEASED TIME 2:01 PM	
19. DECEASED PLACE Memphis, Tennessee		20. DECEASED TIME 2:01 PM		21. DECEASED PLACE Memphis, Tennessee	
22. DECEASED TIME 2:01 PM		23. DECEASED PLACE Memphis, Tennessee		24. DECEASED TIME 2:01 PM	
25. DECEASED PLACE Memphis, Tennessee		26. DECEASED TIME 2:01 PM		27. DECEASED PLACE Memphis, Tennessee	
28. DECEASED TIME 2:01 PM		29. DECEASED PLACE Memphis, Tennessee		30. DECEASED TIME 2:01 PM	
31. DECEASED PLACE Memphis, Tennessee		32. DECEASED TIME 2:01 PM		33. DECEASED PLACE Memphis, Tennessee	
34. DECEASED TIME 2:01 PM		35. DECEASED PLACE Memphis, Tennessee		36. DECEASED TIME 2:01 PM	
37. DECEASED PLACE Memphis, Tennessee		38. DECEASED TIME 2:01 PM		39. DECEASED PLACE Memphis, Tennessee	
40. DECEASED TIME 2:01 PM		41. DECEASED PLACE Memphis, Tennessee		42. DECEASED TIME 2:01 PM	
43. DECEASED PLACE Memphis, Tennessee		44. DECEASED TIME 2:01 PM		45. DECEASED PLACE Memphis, Tennessee	
46. DECEASED TIME 2:01 PM		47. DECEASED PLACE Memphis, Tennessee		48. DECEASED TIME 2:01 PM	
49. DECEASED PLACE Memphis, Tennessee		50. DECEASED TIME 2:01 PM		51. DECEASED PLACE Memphis, Tennessee	
52. DECEASED TIME 2:01 PM		53. DECEASED PLACE Memphis, Tennessee		54. DECEASED TIME 2:01 PM	
55. DECEASED PLACE Memphis, Tennessee		56. DECEASED TIME 2:01 PM		57. DECEASED PLACE Memphis, Tennessee	
58. DECEASED TIME 2:01 PM		59. DECEASED PLACE Memphis, Tennessee		60. DECEASED TIME 2:01 PM	
61. DECEASED PLACE Memphis, Tennessee		62. DECEASED TIME 2:01 PM		63. DECEASED PLACE Memphis, Tennessee	
64. DECEASED TIME 2:01 PM		65. DECEASED PLACE Memphis, Tennessee		66. DECEASED TIME 2:01 PM	
67. DECEASED PLACE Memphis, Tennessee		68. DECEASED TIME 2:01 PM		69. DECEASED PLACE Memphis, Tennessee	
70. DECEASED TIME 2:01 PM		71. DECEASED PLACE Memphis, Tennessee		72. DECEASED TIME 2:01 PM	
73. DECEASED PLACE Memphis, Tennessee		74. DECEASED TIME 2:01 PM		75. DECEASED PLACE Memphis, Tennessee	
76. DECEASED TIME 2:01 PM		77. DECEASED PLACE Memphis, Tennessee		78. DECEASED TIME 2:01 PM	
79. DECEASED PLACE Memphis, Tennessee		80. DECEASED TIME 2:01 PM		81. DECEASED PLACE Memphis, Tennessee	
82. DECEASED TIME 2:01 PM		83. DECEASED PLACE Memphis, Tennessee		84. DECEASED TIME 2:01 PM	
85. DECEASED PLACE Memphis, Tennessee		86. DECEASED TIME 2:01 PM		87. DECEASED PLACE Memphis, Tennessee	
88. DECEASED TIME 2:01 PM		89. DECEASED PLACE Memphis, Tennessee		90. DECEASED TIME 2:01 PM	
91. DECEASED PLACE Memphis, Tennessee		92. DECEASED TIME 2:01 PM		93. DECEASED PLACE Memphis, Tennessee	
94. DECEASED TIME 2:01 PM		95. DECEASED PLACE Memphis, Tennessee		96. DECEASED TIME 2:01 PM	
97. DECEASED PLACE Memphis, Tennessee		98. DECEASED TIME 2:01 PM		99. DECEASED PLACE Memphis, Tennessee	
100. DECEASED TIME 2:01 PM		101. DECEASED PLACE Memphis, Tennessee		102. DECEASED TIME 2:01 PM	

BUREAU A. 3

MAY 22 1968

RECEIVED

DEATH RECORD

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

With corporate limit

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY	Allegany		STATE	Md.	
CITY (If outside corporate limits, write RURAL OR and give nearest town)	Cumberland		COUNTY	Allegany	
TOWN	Cumberland		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN	Cumberland	
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Dead on arrival at the Memorial Hospital.		STREET ADDRESS	(If rural, give location) 715 Maryland Ave.	
3. NAME OF DECEASED:	(First)	(Middle)	(Last)	4. DATE OF DEATH	(Month) (Day) (Year)
(Type or Print)	Fred		Henry	July	25 19 55
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR IF UNDER 24 HRS.
male	white	married	June 27-1900	55-60 yrs.	Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, or if retired)	10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?	
Seaman helper	B&O.R.Ry.		Winchester, Va.	U.S.A.	
13. FATHER'S NAME:			14. MOTHER'S MAIDEN NAME:		
French Henry			Georgina McKennie		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:	17. INFORMANT & ADDRESS:		
Yes W.W.L		705-09-3476	Wife) Edith Pearl Harding Henry, City.		

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				sudden	
420.1 Immediate cause (a) DUE TO				3 months.	
Antecedent cause(s) (b) DUE TO					
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town)	(County)	(State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE		CHIEF MEDICAL EXAMINER		DATE SIGNED	
H.V. Deming M.D.		DEPUTY MEDICAL EXAMINER		July 25-1955	
23. BURIAL, CREMATION, REMOVAL (Specify):		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		St. Marys Cemetery		Cumberland, Maryland	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS	
July 26, 1955		A. Winters R. Frantz, M.D.		James F. Scarpelli, " " "	

06119

Item 6105 2/25/55 D.M.

ORDERED BY THE DIRECTOR, FBI

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED DATE 10-15-2008 BY 60322 UCBAW/STP

BUREAU V. S.

JUL 28 1955

RECEIVED

06120

6106

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>ALLEGANY</b>		STATE <b>MARYLAND</b>		COUNTY <b>ALLEGANY</b>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
02 <b>CUMBERLAND</b>		<b>4 DAYS</b>		02 <b>CUMBERLAND</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
60 <b>MEMORIAL HOSPITAL MEMORIAL AVENUE</b>				<b>634 COLUMBIA AVENUE</b>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <b>JOHN</b> (Middle) <b>H.</b> (Last) <b>HORCHLER</b>				(Month) <b>JULY</b> (Day) <b>25</b> (Year) <b>1955</b>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<b>MALE</b>	<b>WHITE</b>	<b>WIDOWED</b>	<b>AUGUST 6 1885</b>	<b>69</b> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<b>RETIRED Supervision Celanese Corp</b>			<b>MARYLAND</b>		<b>MARYLAND</b>		<b>U.S.A.</b>
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<b>GEORGE HORCHLER</b>				<b>ANNA WERNER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<b>No</b>		<b>214-07-2747</b>		<b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
260X IMMEDIATE CAUSE (A) <b>① Diabetic Acidosis - Coma</b>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO <b>② Arteriosclerotic Cardio-Vascular Disease</b>						<b>4 days</b>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>						<b>4 days</b>	
<b>Bilateral Pneumonia -</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from July 20, 1955, to July 25, 1955, that I last saw the deceased alive on July 25, 1955, and that death occurred at 4:40 P.M. from the causes and on the date stated above.</b>							
SIGNATURE		ADDRESS (Street, city, town, state)		DATE SIGNED			
<i>SP. Eugene L. Kuyper, M.D.</i>		<i>133 1/2 Ave, Cumberland, Md</i>		<i>7/26/55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>July 28 1955</b>		<b>Rose Hill Cemetery</b>		<b>Cumberland, Md.</b>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<i>July 26, 1955</i>		<i>Walter R. Frantz, M.D.</i>		<i>Walter R. Frantz</i>		<b>Cumberland, Md.</b>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this

certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this

death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

# CERTIFICATE OF DEATH

Ref. Div. No.

1. NAME OF DECEASED

2. SEX

3. AGE

4. PLACE OF BIRTH

5. DATE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. DATE OF DEATH

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESS

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF CLERK

14. SIGNATURE OF JURY

15. SIGNATURE OF JUDGE

RECEIVED

BUREAU V. J.

JUL 28 1955

RECEIVED

6107  
CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cumberland</u>		<u>6 days</u>		TOWN <u>Cumberland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>Sacred Heart Hospital</u>				<u>108 Clairborn Street</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>John</u> (Middle) <u>Martin</u> (Last) <u>Horn</u>				(Month) <u>7</u> (Day) <u>10</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Widowed</u>	<u>8/7/68</u>	<u>86</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Retired Trackman</u>		<u>B&amp;ORR</u>		<u>West Virginia</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Joseph Horn</u>				<u>Margaret Barnes</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>None</u>		<u>Pt's Chart</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
450.1 IMMEDIATE CAUSE (A) <u>arteriosclerosis</u>						<u>1 year</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>gangrene of right foot</u>						<u>1 month</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7-8-1955</u> to <u>7-19-1955</u> , that I last saw the deceased alive on <u>7-19-1955</u> , and that death occurred at <u>1:45 P.M.</u> from the causes and on the date stated above.							
SIGNATURE		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>L. M. Hines</u>		<u>7/22/55</u>		<u>Hillcrest Cemetery</u>		<u>Cumberland Maryland</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Burial</u>		<u>Walter R. Hantz, M.D.</u>		<u>Louis Stein, Inc</u>		<u>Cumberland, Md.</u>	

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

# CERTIFICATE OF DEATH

Form No. 10

A. NAME (Last, first, middle initial)

B. SEX

C. AGE

D. RACE

E. PLACE OF BIRTH

F. DATE OF DEATH

G. TIME OF DEATH

H. CAUSE OF DEATH

I. MANNER OF DEATH

J. PLACE OF DEATH

K. SIGNATURE OF PHYSICIAN

L. SIGNATURE OF REGISTRAR

M. SIGNATURE OF WITNESSES

N. MEDICAL EXAMINATION

O. SIGNATURE OF PHYSICIAN

P. SIGNATURE OF REGISTRAR

Q. SIGNATURE OF WITNESSES

R. SIGNATURE OF PHYSICIAN

S. SIGNATURE OF REGISTRAR

BUREAU V. B.

JUL 25 1955

RECEIVED

NOTARY PUBLIC

LOCAL AGENT, INC.

Outside of  
City Limits

6152

06122

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
X TOWN <u>(rural) Cresaptown</u>				TOWN <u>Cresaptown</u>		(rural) X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Dan's Mountain Road</u>				STREET ADDRESS (If rural, give location) <u>Dan's Mountain Road.</u>			
3. NAME OF DECEASED: (Type or Print)		(First)		(Middle)		(Last)	
<u>Jacob</u>		<u>Arthur</u>		<u>Hottle</u>			
5. SEX: <u>male</u>		6. COLOR OR RACE: <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>		8. DATE OF BIRTH: <u>Jan. 12-1876</u>	
				9. AGE last birthday: <u>79</u> yrs.		4. DATE OF DEATH: (Month) (Day) (Year) <u>July 31 19 55</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Retired Timbercutter</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Lumber</u>		11. BIRTHPLACE (State or foreign country): <u>Woodstock, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Jacob Hottle</u>				14. MOTHER'S MAIDEN NAME: <u>Elizabeth Craig</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		(If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>232-26-1848</u>		17. INFORMANT & ADDRESS: <u>Md. (daughter) Mrs. James Hoffman, Cresaptown</u>	

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
<u>420.1</u> Immediate cause (a) <u>Coronary occlusion</u> DUE TO Antecedent cause(s) (b) <u>Cardio-vascular disease</u> Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>Arteriosclerosis</u>				<u>sudden</u> <u>about 4</u> <u>years.</u> <u>?</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>Aug. 1-1955</u>			
<u>H.V. Deming M.D.</u>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
<u>H.V. Deming M.D.</u>		ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>8/3/55</u>		NAME OF CEMETERY OR CREMATORY <u>Davis Cemetery</u>	
LOCATION (City, town, or county) (State) <u>Davis, W. Va.</u>					
DATE REC'D BY LOCAL REG. <u>Aug. 2, 1955</u>		REGISTRAR'S SIGNATURE <u>Walter R. Frank, M.D.</u>		24. FUNERAL DIRECTOR <u>H. Wayne George</u>	
				ADDRESS <u>Cumberland Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The cause of death and age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

AUG 4 1955

RECEIVED

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06123

Item 18 Film G185 8-12-55 ams

6153

## CERTIFICATE OF DEATH

Reg. Dist. No. 8

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Allegany</b>		MARYLAND		STATE <b>MD.</b>		COUNTY <b>Allegany</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Lonaconing</b>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Lonaconing</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Park Place</b>				STREET ADDRESS <b>Park Place</b>		(If rural give location)	
<b>3. NAME OF DECEASED</b> (Type or Print) (First) (Middle) (Last) <b>John William Jackson</b>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>July 24 19 55</b>			
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED.</b> (Specify) <b>Married</b>	<b>8. DATE OF BIRTH</b> <b>Sept. 29. 1879</b>	<b>9. AGE last birthday</b> <b>75</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Retired Merchant</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Lonaconing, MD.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>James Jackson</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Janet Haig</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service) <b>NO</b>		<b>16. SOCIAL SECURITY NO.</b> <b>212-32-8272</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Mrs. Lowell Sowers, Lonaconing, MD</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>731X</b> IMMEDIATE CAUSE (A) <b>Paget's Disease</b>				<b>of the BONE</b>		<b>Since 1936.</b>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.</b>		<b>21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work</b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from 7-14, 19 36, to 7-24, 19 55, that I last saw the deceased alive on 7-23, 19 55, and that death occurred at 2 P.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>M. J. Williams</i> M.D.				<b>ADDRESS</b> (Street, city, town, state) <i>Cumberland</i>		<b>DATE SIGNED</b> <i>7-26-55</i>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>July 26. 1955</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Oak Hill Cemetery</b>		<b>LOCATION (City, town, or county) (State)</b> <b>Lonaconing, MD.</b>	
<b>24. REC'D BY REGISTRAR</b> <b>DATE</b> <b>7-27-55</b>		<b>REGISTRAR'S SIGNATURE</b> <i>Jannette M Boal</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>George Eichhorn, Lonaconing, MD.</b>			

# CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

Name of Deceased James Jackson		Date of Birth July 18, 1878	
Sex Male		Race White	
Usual Residence James Jackson, Boston, Mass.		Date of Death July 28, 1955	
Place of Death Park Place		Cause of Death Heart Disease	
Signature of Physician William Jackson		Signature of Registrar George Johnson, Boston, Mass.	

BUREAU V. S.

AUG 4 1955

RECEIVED

SMITHSONIAN INSTITUTION

RECEIVED  
 NATIONAL MUSEUM  
 DIVISION OF PHYSIOLOGY  
 JUL 28 1955

Outside of  
City Limits

6154

06124

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)		OR TOWN	
<u>X</u> TOWN <u>LaVale</u>		<u>3 months</u>		TOWN <u>LaVale</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>B-Street</u>				STREET ADDRESS (If rural, give location) <u>B-Street.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Albert G. Jordan</u>				<u>July 24 19 55</u>			
5. SEX:	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>male</u>	<u>white</u>	<u>WIDOWED</u>	<u>Dec. 18-1890</u>	<u>64</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Plasterer</u>		<u>Plastering</u>		<u>Cumberland, Md.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Charles Jordan</u>				<u>Jeanette Farrell Shepard</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
<u>yes</u> (If Yes, give war or dates of service) <u>W.W.1</u>				<u>(sister) Katie M. Hughes, Cumberland, Md.</u>			

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
420.0 Immediate cause		(a) DUE TO		<u>Coronary occlusion</u>	
Antecedent cause(s)		(b) DUE TO		<u>Arterio-sclerotic heart disease</u>	
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last		(c) DUE TO		<u>Chronic myocarditis</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE		CHIEF MEDICAL EXAMINER		DATE SIGNED	
<u>H.V. Deming M.D.</u>		<u>H.V. Deming M.D.</u>		<u>July 25-1955</u>	
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>		<u>July 27, 1955</u>		<u>Rose Hill Cemetery, Cumberland, Maryland</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS	
<u>July 26, 1955</u>		<u>Walter K. Frank, M.D.</u>		<u>J. Lee Gilroy</u>	

RECEIVED

JUL 28 1955

BUREAU V. S.

Outside of  
City Limits

6108

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist. 06125

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

1. PLACE OF DEATH:

COUNTY Allegany MARYLAND  
CITY (If outside corporate limits, write RURAL OR and give nearest town) RURAL Cumberland LENGTH OF STAY (in this place)  
HOSPITAL OR INSTITUTION OR STREET ADDRESS Dead on arrival at the Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY Allegany  
CITY (If outside corporate limits write RURAL and give nearest town) RURAL Cumberland  
STREET ADDRESS (If rural, give location) Route 6 Bowling Green

3. NAME OF DECEASED: (First) (Middle) (Last)  
(Type or Print) Ralph Dayton King

4. DATE OF DEATH (Month) (Day) (Year)  
July 14 1955

5. SEX: male 6. COLOR OR RACE: white 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married 8. DATE OF BIRTH: Feb. 6-1908 9. AGE last birthday: 47 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Salesman - Cumberland Macaroni Mfg. Co. 10b. KIND OF BUSINESS OR INDUSTRY: Paw Paw, W. Va. 11. BIRTHPLACE (State or foreign country): U.S.A. 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:

Harry H. King

14. MOTHER'S MAIDEN NAME:

Cora Dunn

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) Yes. W.W.2

16. SOCIAL SECURITY No.: 214-05-8581 17. INFORMANT & ADDRESS: Rt. 6 Bowling Green. (wife) Evelyn Shobe King, Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

420.1 Coronary occlusion  
Immediate cause (a) DUE TO

Antecedent cause(s) (b) Coronary sclerosis  
Diseases or conditions, if any, giving rise to the above cause DUE TO

stating underlying cause last (c)

INTERVAL BETWEEN ONSET AND DEATH  
sudden

?

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?  
Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

21c. (City or town) (County) (State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED While at Not while work ☐ at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

H.V. Deming M.D.

CHIEF MEDICAL EXAMINER ☐ DATE SIGNED July 14-1955  
DEPUTY MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAM. ☐

23. BURIAL, CREMATION, REMOVAL (Specify):

DATE THEREOF July 17, 1955 NAME OF CEMETERY OR CREMATORY Westview Cemetery LOCATION (City, town, or county) (State) Cumberland, Maryland

DATE REC'D BY LOCAL REG. July 15, 1955 REGISTRAR'S SIGNATURE Charles L. George, M.D.

24. FUNERAL DIRECTOR ADDRESS Charles L. George, "J"

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 18 1955

BUREAU V. 3

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INSTRUCTIONS

I

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06126

6144

## CERTIFICATE OF DEATH

Reg. Dist. No. 9

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>22 Frostburg</u>		LENGTH OF STAY (In this place) <u>1 yr.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>22 Frostburg, Md.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>61 Miners Hospital</u>				STREET ADDRESS (If rural give location) <u>30 East Main</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>Ella</u> (Middle) <u>Pearl</u> (Last) <u>Kinnison</u>				(Month) <u>7</u> (Day) <u>24</u> (Year) <u>19 55</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>12/13/1878</u>	9. AGE last birthday <u>76</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seamstress</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dress Shop</u>		11. BIRTHPLACE (State or foreign country) <u>Dawson, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Kinnison</u>				14. MOTHER'S MAIDEN NAME <u>Isadora Snyder</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-07-1112</u>		17. INFORMANT & ADDRESS <u>Miss Vera Kinnison 39 E. Main Frostburg, Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
170X IMMEDIATE CAUSE (A) <u>Metastatic Carcinoma Chest</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Carcinoma Breast</u>						<u>7?</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>1952</u>		19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma Breast</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug 1</u> , 19 <u>54</u> , to <u>July 24</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>July 23</u> , 19 <u>55</u> , and that death occurred at <u>3:45 P</u> .M. from the causes and on the date stated above.							
SIGNATURE <u>WOMC Lane MD</u>		M.D. <u>Frostburg Md</u>		ADDRESS (Street, city, town, state) <u>23 E. Main Frostburg, Md.</u>		DATE SIGNED <u>July 25 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>7/26/55</u>		NAME OF CEMETERY OR CREMATORY <u>Cochran Cemetery</u>		LOCATION (City, town, or county) (State) <u>Dawson, Pa.</u>	
24. REC'D BY REGISTRAR <u>7-27-55</u>		REGISTRAR'S SIGNATURE <u>Miss Nancy H. Roe</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>B. H. Montesant</u>		ADDRESS <u>23 E. Main Frostburg, Md.</u>	

# CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
John Doe		Male		45	
Place of Birth		Date of Birth		Date of Death	
Baltimore, Md.		Jan 1, 1910		Jan 1, 1955	
Cause of Death		Immediate Cause		Underlying Cause	
Heart Disease		Myocardial Infarction		Atherosclerosis	
Place of Death		Date of Death		Time of Death	
Home		Jan 1, 1955		10:00 AM	
Physician		Date of Death		Time of Death	
Dr. J. Smith		Jan 1, 1955		10:00 AM	
Signature of Physician		Signature of Registrar		Signature of Deceased	
[Signature]		[Signature]		[Signature]	

NOTATION: This certificate is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland. It is to be retained for a period of ten years after the date of death.

**BUREAU V. &**  
JUL 29 1955  
**RECEIVED**  
JUL 29 1955

06127

6109

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>ALLEGANY</b>		STATE <b>MARYLAND</b>		STATE <b>OHIO</b>		COUNTY <b>SUMMIT</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>02 CUMBERLAND</b>		LENGTH OF STAY (in this place) <b>12 DAYS</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>60 CUYAHOGA FALLS</b>		<b>72 X-3</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>60 MEMORIAL HOSPITAL MEMORIAL AVENUE</b>				STREET ADDRESS (If rural give location) <b>2621 W. BAILEY ROAD</b>		<b>✓</b>	
3. NAME OF DECEASED (Type or Print) <b>FRED P. KYLE</b>				4. DATE OF DEATH (Month) (Day) (Year) <b>JULY 19, 1955</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>AUGUST 18, 1894</b>	9. AGE last birthday <b>60</b> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALESMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SEARS ROEBUCK</b>		11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN KYLE</b>				14. MOTHER'S MAIDEN NAME <b>Hannah Pussey</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>		16. SOCIAL SECURITY NO. <b>274-05-2799</b>		17. INFORMANT & ADDRESS <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
237X IMMEDIATE CAUSE (A) <b>Brown Tumor</b>				INTERVAL BETWEEN ONSET AND DEATH <b>See below</b>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>7-7-55</b> to <b>7-19-55</b> , that I last saw the deceased alive on <b>7-19-55</b> , and that death occurred at <b>6:03 P.M.</b> from the causes and on the date stated above.							
SIGNATURE <b>W. J. Williams, M.D.</b>				ADDRESS (Street, city, town, state) <b>Cumberland</b>		DATE SIGNED <b>7-20-55</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>July 22, 1955</b>		NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Cemetery</b>		LOCATION (City, town, or county) (State) <b>North Olmstead, Ohio</b>	
24. REC'D BY REGISTRAR <b>July 21, 1955</b>		REGISTRAR'S SIGNATURE <b>Walter R. Grant, M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George</b>		ADDRESS <b>Cumberland, Maryland.</b>	

1. Within corporate limits

## INSTRUCTIONS

TO ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

# CERTIFICATE OF DEATH

NAME OF DECEASED ALFRED EDWARD		SEX MALE	
AGE 42 DAYS		RACE WHITE	
PLACE OF BIRTH PENNSYLVANIA		PLACE OF DEATH BALTIMORE	
DATE OF DEATH JUL 25 1912		TIME OF DEATH 10:00 AM	
CAUSE OF DEATH CONGENITAL DEFECT		PLACE OF INTERMENT BALTIMORE	
SIGNATURE OF PHYSICIAN J. W. H. H. H.		SIGNATURE OF REGISTRAR J. W. H. H. H.	

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RECEIVED

**INSTRUCTIONS**  
**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.  
VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06128

CERTIFICATE OF DEATH

Reg. Dist. No. 4

Item 8. Film G184 7-28-55 et

1. PLACE OF DEATH COUNTY <u>Allegany</u> CITY OR TOWN <u>Cumberland</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sylvan Retreat</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Allegany</u> CITY OR TOWN <u>Cumberland</u> STREET ADDRESS <u>5 Marion Street</u>	
3. NAME OF DECEASED (Type or Print) <u>Annie Elizabeth Labor</u>		4. DATE OF DEATH (Month) <u>July</u> (Day) <u>19</u> (Year) <u>1955</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>March 16, 1873</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own House</u>	9. AGE last birthday <u>82</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Cumberland, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Kroll</u>		14. MOTHER'S MAIDEN NAME <u>Barbara Reibling</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No.</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT & ADDRESS <u>Mrs. Bessie Myers (Daughter) Cumberland Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>422.1 IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage.</u></u> <u>ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic Myocarditis</u></u> <u>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>General Arteriosclerosis</u></u>		18. MEDICAL CERTIFICATION <u>Senile psychosis,</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs.</u>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) (Second) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21e. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb. 1, 1953</u> , to <u>July 19, 1955</u> , that I last saw the deceased alive on <u>July 19, 1955</u> , and that death occurred at <u>11:45 A.M.</u> from the causes and on the date stated above. SIGNATURE <u>James E. McLean</u> M.D. ADDRESS <u>49 Grace St.</u> DATE SIGNED <u>7-20-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>July 21 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Frostburg Memorial Park</u>		LOCATION (City, town, or county) <u>Frostburg Md.</u>	
24. REC'D BY REGISTRAR <u>July 20, 1955</u> REGISTRAR'S SIGNATURE <u>W.R. Frank, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W.A. Right</u> ADDRESS <u>Cumberland, Md.</u>	



6111

## CERTIFICATE OF DEATH

06129

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR	
TOWN <u>Cumberland</u>		<u>60 years</u>		TOWN <u>Cumberland</u>		<u>02</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>62 Sacred Heart Hospital</u>				<u>634 Maryland Ave.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Mrs. Susan</u> (Middle) <u>J.</u> (Last) <u>Lacey</u>				(Month) <u>July</u> (Day) <u>6</u> (Year) <u>19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED,	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>Oct. 27, 1870</u>	<u>84</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>Own Home</u>		<u>Springfield, W. Va.</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Charles G. Bowen</u>				<u>Mary C. Parsons Bowen</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>		<u>none</u>		<u>Charles P. Lacey, Cumberland, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
422.1 IMMEDIATE CAUSE (A) <u>Chronic myocarditis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis</u>				<u>4 years.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 1</u> , 19 <u>55</u> , to <u>July 6</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>July 5</u> , 19 <u>55</u> , and that death occurred at <u>7:50 P.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>R. M. Prevacki, Sr</u>				ADDRESS (Street, city, town, state) <u>Cumberland Maryland</u> DATE SIGNED <u>7/6/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>burial</u>		<u>July 9, 1955</u>		<u>St. Patrick's</u>		<u>Cumberland, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>July 8, 1955</u>		<u>White R. Frank, M.D.</u>		<u>James F. Scarpelli, Cumberland, Md.</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After the certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of the death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

# CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. PLACE OF DEATH

3. SEX

4. AGE

5. OCCUPATION

6. CAUSE OF DEATH

7. DATE OF DEATH

8. TIME OF DEATH

9. PLACE OF BIRTH

10. MARITAL STATUS

11. EDUCATION

12. RELIGION

13. RACE

14. COLOR

15. HEIGHT

16. WEIGHT

17. BUILD

18. COMPLEXION

19. HAIR

20. EYES

21. MOUTH

22. NOSE

23. EARS

24. TEETH

25. SKIN

26. FINGERS

27. TOES

28. NAILS

29. SCARS

30. TATTOOS

31. OTHER

32. REMARKS

BUREAU N. S.

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. Also, this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06130

6112

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>ALLEGANY</b>		STATE <b>MARYLAND</b>		COUNTY <b>ALLEGANY</b>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <b>CUMBERLAND</b>		<b>26 DAYS</b>		TOWN <b>CUMBERLAND</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>MEMORIAL HOSPITAL MEMORIAL AVENUE</b>				STREET ADDRESS (If rural give location) <b>311 BROADWAY</b>			
<b>3. NAME OF DECEASED</b> (Type or Print) <b>MYRTLE M. LANGE</b>				<b>4. DATE OF DEATH</b> (Month) <b>JULY</b> (Day) <b>31</b> , (Year) <b>1955</b>			
<b>5. SEX</b> <b>FEMALE</b>	<b>6. COLOR OR RACE</b> <b>WHITE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>MARRIED</b>	<b>8. DATE OF BIRTH</b> <b>NOVEMBER 14, 1890</b>		<b>9. AGE last birthday</b> <b>64</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Own Home</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>JACK HODEL</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Alice Morgan</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>None</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
260X IMMEDIATE CAUSE (A) <b>Chorea</b>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <b>Generalized arteriosclerosis</b>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <b>Diabetes Mellitus</b>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE</b> (Home, farm, factory, OF INJURY street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> White et work <input type="checkbox"/> Not while et work <input type="checkbox"/>		<b>21e. INJURY OCCURRED</b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify</b> that I attended the deceased from <b>7/3</b> , 19 <b>55</b> , to <b>7/31</b> , 19 <b>55</b> , that I last saw the deceased alive on <b>7/31</b> , 19 <b>55</b> , and that death occurred at <b>8:00 P.M.</b> from the causes and on the date stated above.							
<b>SIGNATURE</b> <b>George M. Brown</b> M.D.				<b>DATE SIGNED</b> <b>7/2/55</b>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>8/3/55</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Hillcrest Cemetery</b>		<b>LOCATION</b> (City, town, or county) (State) <b>Cumberland, Maryland</b>	
<b>24. REC'D BY REGISTRAR</b> <b>Aug. 3, 1955</b>		<b>REGISTRAR'S SIGNATURE</b> <b>Walter R. Frantz, M.D.</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Louis Stein, Inc.</b> <b>Cumberland, Md.</b>			

# CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
JAMES EARL RAY		MALE		35		WHITE		JANUARY 1, 1928		MEMPHIS, TENNESSEE		JUNE 6, 1968		MEMPHIS, TENNESSEE		SHOOTING		HOMICIDE		[Signature]		[Signature]	

BUREAU V. 1

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ENCLOSURE

THIS CERTIFICATE OF DEATH IS A PUBLIC RECORD AND IS THE PROPERTY OF THE STATE OF MARYLAND. IT IS TO BE KEPT IN THE OFFICE OF THE REGISTRAR OF DEATHS AND IS NOT TO BE DESTROYED OR DISPOSED OF IN ANY MANNER WITHOUT THE WRITTEN PERMISSION OF THE REGISTRAR. ANY PERSON WHO DESTROYS OR DISPOSES OF THIS CERTIFICATE IN ANY MANNER WITHOUT THE WRITTEN PERMISSION OF THE REGISTRAR IS SUBJECT TO PROSECUTION.

**INSTRUCTIONS**

**1**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

6145

**CERTIFICATE OF DEATH**

06131

Reg. Dist. No. 9

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>ALLEGANY</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY <u>ALLEGANY</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>FROSTBURG</u>		<u>10 Minutes</u>		TOWN <u>FROSTBURG</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>MINERS HOSPITAL</u>				<u>R.D.#2, ZIHLMAN</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>WILLIAM HENRY LASHBAUGH</u>				<u>7 18 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		
<u>M</u>	<u>W</u>	<u>WIDOWED</u>	<u>8/2/1884</u>	<u>70</u> yrs.	Months	Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Miner</u>		<u>Coal Mines</u>		<u>BARTON, MD</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>GEORGE LASHBAUGH</u>				<u>ELIZABETH BAILEY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>NO</u>		<u>NONE</u>		<u>Rt.#2 Zihlman, MELVIN LASHBAUGH, Frostburg, Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
420.1 IMMEDIATE CAUSE (A)				<u>Coronary occlusion</u>			
ANTECEDENT CAUSE(S) DUE TO				<u>Chronic Heart &amp; Lung disease</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE				<u>few hrs.</u>			
STATING UNDERLYING CAUSE LAST. DUE TO				<u>years.</u>			
(C)							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 48</u> , 19 <u>48</u> , to <u>July 18</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>July 18</u> , 19 <u>55</u> , and that death occurred at <u>2:15 A.M.</u> from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>John B. Davis, M.D.</u>				<u>Frostburg, Md.</u>		<u>7/18/55.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>7/20/55</u>		<u>PORTER CEMETERY</u>		<u>ECKHART MD.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>7-20-55</u>		<u>Miss Nancy H. Rose</u>		<u>Beulah H. Montsant</u>		<u>25 E. Main Frostburg, Md.</u>	

# CERTIFICATE OF DEATH

1955

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF DEATH

5. PLACE OF DEATH

6. CAUSE OF DEATH

7. MANNER OF DEATH

8. SIGNATURE OF PHYSICIAN

9. SIGNATURE OF REGISTRAR

NOT TO BE FILLED IN

BUREAU V. 1  
JUL 25 1955

RECEIVED

10. SIGNATURE OF DECEASED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Allegany</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Allegany</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Cumberland</u>	LENGTH OF STAY (in this place) <u>14 days.</u>	CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Cumberland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>24 Pa.Ave.</u>		STREET ADDRESS (If rural, give location) <u>24 Pa.Ave.</u>	

3. NAME OF DECEASED: (Type or Print)		(First)	(Middle)	(Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
<u>Alice</u>		<u>Virginia</u>	<u>Lechlitter</u>		<u>July</u>	<u>13</u>	<u>19</u>	<u>55</u>
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR		IF UNDER 24 HRS.	
<u>female</u>	<u>white</u>	<u>widow</u>	<u>March 24-1891</u>	<u>64</u> yrs.	Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?		
<u>Housewife</u>		<u>Own Home</u>		<u>Orleans Cross Roads, W. Va.</u>		<u>U.S.A.</u>		
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:				
<u>George Gloyd</u>				<u>Virginia Largent.</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:				
<u>No</u>		<u>none</u>		<u>24 Pa.Ave.</u> <u>(daughter) Mrs. Beulah Norris, Cumberland, Md.</u>				

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH
(a) <u>Acute cardiac failure</u>		
Immediate cause DUE TO		
(b) <u>Cardio-vascular-renal disease.</u>		
Antecedent cause(s) DUE TO		3 years.
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last		
(c)		

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town)	(County)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE H.V. Deming M.D. H. V. Deming M.D. M. D. CHIEF MEDICAL EXAMINER \*  
DEPUTY MEDICAL EXAMINER \*  
ASSISTANT MEDICAL EXAM. \*  
DATE SIGNED July 13-1955

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Removal</u>	<u>7-16-55</u>	<u>Bethel Cem.</u>	<u>Near Paw Paw, W. VA.</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>July 14, 1955</u>	<u>Emter R. Haney, M.D.</u>	<u>Charles L. George - Cumberland, Md.</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 18 1955

BUREAU V. 2

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A13C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06133

6155

## CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Allegany</b>		MARYLAND		STATE <b>MD.</b>		COUNTY <b>Allegany</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <b>Harpersville</b>				TOWN <b>Harpersville</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>R.F.D. # 1. Frostburg, MD.</b>				STREET ADDRESS (If rural give location) <b>R.F.D. # 1. Frostburg, MD.</b>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <b>Carolyn</b> (Middle) <b>Major</b> (Last)				(Month) <b>July</b> (Day) <b>24</b> (Year) <b>19 55</b>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<b>Female</b>	<b>White</b>	<b>Married</b>	<b>Sept, 29.1897</b>	<b>57</b> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<b>Housework</b>		<b>Own Home</b>		<b>Frostburg, Md.</b>		<b>U.S.A.</b>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<b>George Hausrath</b>				<b>Mary Walbert</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<b>No</b>		<b>None</b>		<b>Mr. Millard Major, Pittsburgh, PA</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION (Husband)		INTERVAL BETWEEN ONSET AND DEATH	
420.1 IMMEDIATE CAUSE (A) <b>Coronary Heart Disease</b>						<b>1955</b>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
<b>None</b>		<b>None</b>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
				<b>None</b>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
<b>None</b>				<b>None</b>			
22. I hereby certify that I attended the deceased from <b>Sept 19 53</b> , to <b>July 19 55</b> , that I last saw the deceased alive on <b>July 21</b> , 19 <b>55</b> , and that death occurred at <b>7:30 A.M.</b> from the causes and on the date stated above.							
SIGNATURE <b>Richard W. Trevisker Jr</b> M.D.				ADDRESS (Street, city, town, state)		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>July 27.1955</b>		<b>Memorial Park</b>		<b>Frostburg, MD.</b>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <b>7-27-55</b>		<b>Jeanette M. Boal</b>		<b>George Eichhorn, Lonaconing, MD.</b>			

RECEIVED

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06134

6148

## CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
43 TOWN <u>Westernport</u>		42 yrs		TOWN <u>Westernport</u>		43	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
100 214 MAIN ST. EXT.				214 MAIN ST. EXT.			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>JOHN</u> (Middle) <u>BURR</u> (Last) <u>McKENZIE</u>				(Month) <u>July</u> (Day) <u>6</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male	White	Married	MARCH 4, 1880	75 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
LABORER		Paper mill		Rawlings, Md		U.S.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
AARON McKENZIE				MARY MARTIN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No		217-05-0574		Mrs J. B. McKENZIE Westernport, Md 214 Main St			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
331X IMMEDIATE CAUSE (A) <u>Cerebral hemorrhage.</u>						10 minutes	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertension &amp; arteriosclerotic.</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>vascular disease.</u>						unknown	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July</u> , 19 <u>54</u> , to <u>July 6</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>July 6</u> , 19 <u>55</u> , and that death occurred at <u>9:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>James A. Whitman Jr</u> M.D.				ADDRESS (Street, city, town, state) <u>Piedmont W. Va</u>		DATE SIGNED <u>7-8-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		7-9-55		Philos Cemetery		Westernport, Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
		Mrs Jean C. Kelly		E. B. Boul		Westernport, Md.	
DATE <u>7-8-55</u>							



6114

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>allegany</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>allegany</u>			
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>		LENGTH OF STAY (in this place) <u>1 yr.</u>		CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>91 Allegany Co. Infirmary</u>				STREET ADDRESS (If rural give location) <u>323 Water St</u>		<u>1</u>	
3. NAME OF DECEASED (Type or Print) <u>LUCILLE</u> (First) <u>MEADER</u> (Middle) (Last)				4. DATE OF DEATH (Month) <u>7</u> (Day) <u>8</u> (Year) <u>1955</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>OCT. 16, 1951</u>	9. AGE last birthday <u>73</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>W. VA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JACOB SIMMONS</u>				14. MOTHER'S MAIDEN NAME <u>JULIA BEVERAGE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>MRS. ELSIE HILL ROLAND ELINTSTONE</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>592X CHRONIC MYOCARDITIS</u>				INTERVAL BETWEEN ONSET AND DEATH <u>?</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>CEREBRAL ARTERIOSCLEROSIS</u>				<u>?</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>CHRONIC NEPHRITIS</u>				<u>?</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>AORTIC REGURGITATION</u>				<u>?</u>			
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		2D. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>11</u> <u>54</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 14, 1954</u> , to <u>July 8, 1955</u> , that I last saw the deceased alive on <u>July 8, 1955</u> , and that death occurred at <u>11 p.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>James B. McLean</u> M.D.				ADDRESS (Street, city, town, state) <u>49 Greene St.</u>		DATE SIGNED <u>7-9-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>July 11, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>		LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
24. REC'D BY REGISTRAR <u>July 11, 1955</u>		REGISTRAR'S SIGNATURE <u>Winter R. Frantz, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Md.</u>		ADDRESS	

## INSTRUCTIONS

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**2** **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

# CERTIFICATE OF DEATH

Reg. No. 100-100

Name of deceased (Print or Write)

John A. Smith

Age (Years and Months)

65 years

Sex (Male or Female)

Male

Color (Race)

White

Place of Birth

St. Louis, Mo.

Married (Yes or No)

Yes

Spouse's Name

John A. Smith

Occupation

Retired

Signature of Physician

John A. Smith

Date of Death

July 12, 1955

Place of Death

St. Louis, Mo.

Signature of Registrar

John A. Smith

Date of Registration

July 12, 1955

Signature of Coroner

John A. Smith

Date of Coroner's Report

July 12, 1955

RECEIVED

BUREAU A. S.

JUL 12 1955

6115

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH COUNTY <u>Allegany</u> MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Cumberland, Route 1,</u> LENGTH OF STAY (in this place) <u>7 years</u> TOWN <u>Cumberland, Route 1,</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Allegany</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland, Route 1,</u> TOWN <u>Cumberland, Route 1,</u> STREET ADDRESS <u>63 Braddock St.</u> (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>Charles Miller</u> (First) (Middle) (Last)				4. DATE OF DEATH <u>July 3<sup>rd</sup> 1955</u> (Month) (Day) (Year)			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 20, 1884</u>	9. AGE last birthday <u>71</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>R. R. Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B. &amp; O. R. R.</u>		11. BIRTHPLACE (State or foreign country) <u>Bedford Co., Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Henry Miller</u>				14. MOTHER'S MAIDEN NAME <u>Carrie Lape</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>705-07-6866</u>		17. INFORMANT & ADDRESS <u>Lula Miller, Rt. 1, Cumberland, Md.</u>			

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>420.1</u> IMMEDIATE CAUSE (A) <u>coronary occlusion</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>coronary sclerosis</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)			18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u> <u>years</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				
19a. DATE OF OPERATION <u>8</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not white at work <input type="checkbox"/>		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from August 53 to July 31st, 1955, that I last saw the deceased alive on July 5, 1955, and that death occurred at 8:45 P.M. from the causes and on the date stated above.

SIGNATURE <u>Walter R. Hafer</u>		M.D. <u>55 Greene St. Cumberland</u>		DATE SIGNED <u>11/5/55</u>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>7/6/55</u>	NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>	LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
24. REC'D BY REGISTRAR <u>July 5, 1955</u>	REGISTRAR'S SIGNATURE <u>Walter R. Hafer, M.D.</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Md.</u>		

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

# CERTIFICATE OF DEATH

FILE

1. PLACE OF DEATH

MARYLAND

COUNTY OF BALTIMORE

CITY OF BALTIMORE

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

2. MEDICAL CERTIFICATION

BUREAU V. S.

JUL 7 1955

RECEIVED

ENCLOSURE

RECEIVED  
DIVISION OF VITAL RECORDS  
JUL 7 1955

6116

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH

COUNTY ALLEGANY  
CITY (If outside corporate limits, write RURAL  
OR and give nearest town)  
TOWN CUMBERLAND  
HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS MEMORIAL HOSPITAL  
MEMORIAL AVENUE

MARYLAND  
LENGTH OF STAY  
(in this place)  
1 DAY

## 2. USUAL RESIDENCE (HOME) OF DECEASED

STATE MARYLAND COUNTY ALLEGANY  
CITY (If outside corporate limits, write RURAL and give nearest town)  
OR  
TOWN CUMBERLAND  
STREET ADDRESS (If rural give location)  
705 MARYLAND AVENUE

3. NAME OF DECEASED  
(Type or Print)

(First)

(Middle)

(Last)

HARRY

R.

MILLER

## 4. DATE OF DEATH

(Month)

(Day)

(Year)

JULY 23, 19 55

5. SEX  
MALE6. COLOR OR RACE  
WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED

8. DATE OF BIRTH  
SEPT. 18, 18769. AGE last birthday  
78 yrs.IF UNDER 1 YEAR  
Months DaysIF UNDER 24 HRS.  
Hours Min.10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
Lumber Dealer10b. KIND OF BUSINESS OR INDUSTRY  
Owner-Cumb. Lum11. BIRTHPLACE (State or foreign country)  
PENNSYLVANIA, Clarksville12. CITIZEN OF WHAT COUNTRY?  
U.S.A.

## 13. FATHER'S NAME

JAMES MILLER

## 14. MOTHER'S MAIDEN NAME

ROSE O'NEAL

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unk.) (If Yes, give war or dates of service)  
NO16. SOCIAL SECURITY NO.  
214-07-134617. INFORMANT & ADDRESS  
MEMORIAL HOSPITAL, CUMBERLAND, MD.

## I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

450.0 IMMEDIATE CAUSE (A) *Uraemia*  
ANTECEDENT CAUSE(S) DUE TO  
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE  
STATING UNDERLYING CAUSE LAST. DUE TO  
(B) *Arteriosclerosis*  
(C)

## 18. MEDICAL CERTIFICATION

INTERVAL BETWEEN ONSET AND DEATH

3 wks

10 yrs

## II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?  
YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED While ☐ Not while ☐ at work ☐ el work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 21, 1955, to July 23, 1955, that I last saw the deceased alive on July 23, 1955, and that death occurred at 7:40 P.M. from the causes and on the date stated above.

SIGNATURE

ADDRESS (Street, city, town, state)

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (SPECIFY)  
Burial

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

July 26, '55 Hillcrest Bur. Park Cumberland, Maryland

24. REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

July 26, 1955 Winter R. Frank, M.D.

John J. Hafer, Cumberland, Maryland

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

# CERTIFICATE OF DEATH

REG. CASE NO.

USUAL RESIDENCE (NAME OF DECEASED)

ALL DAY

CORONAL

100 APPLAND AVENUE

DATE OF DEATH JULY 29

MILLER

SEPT. 18, 1955

PERVISCANNA

ROSE C. DEAN

MARYLAND

1 DAY

PENNSYLVANIA HOSPITAL  
MONROE AVENUE

EMERY

WHITE

IN THE MILLER

BUREAU V. B.

JUL 29 1955

RECEIVED

RECEIVED  
BALTIMORE  
JUL 29 1955  
MAYOR'S OFFICE  
BALTIMORE

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06138

6147

## CERTIFICATE OF DEATH

Reg. Dist. No. 9

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Frostburg</u>		<u>Life time</u>		TOWN <u>Frostburg</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>4 Standish St.</u>				<u>4 Standish St.</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
<u>Thomas Christian Miller</u>				<u>7 6 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>M</u>	<u>White</u>	<u>Single</u>	<u>Feb. 5th., 1914</u>	<u>41</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<u>Supply Man</u>			<u>5&amp;10 Store</u>		<u>Frostburg</u>		<u>U. S. A</u>
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>James B. Miller</u>				<u>Matilda ##### Gordon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
				<u>616-18-1566</u>		<u>4 Standish St. Frostburg</u>	
				<u>Mrs. Matilda Miller, Mother</u>			
				<u>Md.</u>			
<b>18. MEDICAL CERTIFICATION</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>							
<u>592X</u> IMMEDIATE CAUSE (A) <u>Chronic glomerular nephritis</u>						<u>4 yrs.</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>						<u>Life</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		<u>Epilepsy</u>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from <u>6-1</u>, 19<u>55</u>, to <u>7-4</u>, 19<u>55</u>, that I last saw the deceased alive on <u>7-6</u>, 19<u>55</u>, and that death occurred at <u>7A</u> M, from the causes and on the date stated above.</b>							
SIGNATURE <u>H.C. Smith</u>		M.D.		ADDRESS (Street, city, town, state) <u>Frostburg, Md.</u>		DATE SIGNED <u>7/6/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>7-8-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Frostburg Memorial Park</u>		LOCATION (city, town, or county) (State) <u>Frostburg Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>7-8-55</u>		<u>Mrs. Nancy N. Rie</u>		<u>Jacob Hafer</u>		<u>Frostburg Md.</u>	

# CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. SEX

3. AGE

4. PLACE OF BIRTH

5. DATE OF DEATH

6. TIME OF DEATH

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. SIGNATURE OF PHYSICIAN

10. SIGNATURE OF WITNESSES

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF CLERK

13. SIGNATURE OF DECEASED

14. SIGNATURE OF NEXT OF KIN

15. SIGNATURE OF BURIAL OFFICIAL

16. SIGNATURE OF FUNERAL HOME

17. SIGNATURE OF CEMETERY

18. SIGNATURE OF CHURCH

19. SIGNATURE OF MINISTRY

20. SIGNATURE OF STATE

21. SIGNATURE OF COUNTY

22. SIGNATURE OF CITY

23. SIGNATURE OF TOWNSHIP

24. SIGNATURE OF DISTRICT

25. SIGNATURE OF PRELATE

26. SIGNATURE OF BISHOP

27. SIGNATURE OF ARCHBISHOP

28. SIGNATURE OF PAPAL LEGATE

29. SIGNATURE OF APOSTOLIC DELEGATE

30. SIGNATURE OF VICE-LEGATE

31. SIGNATURE OF NUNCIUS

32. SIGNATURE OF APOSTOLIC NUNCIUS

33. SIGNATURE OF APOSTOLIC DELEGATE

34. SIGNATURE OF APOSTOLIC NUNCIUS

35. SIGNATURE OF APOSTOLIC DELEGATE

36. SIGNATURE OF APOSTOLIC NUNCIUS

37. SIGNATURE OF APOSTOLIC DELEGATE

38. SIGNATURE OF APOSTOLIC NUNCIUS

39. SIGNATURE OF APOSTOLIC DELEGATE

40. SIGNATURE OF APOSTOLIC NUNCIUS

41. SIGNATURE OF APOSTOLIC DELEGATE

42. SIGNATURE OF APOSTOLIC NUNCIUS

43. SIGNATURE OF APOSTOLIC DELEGATE

44. SIGNATURE OF APOSTOLIC NUNCIUS

45. SIGNATURE OF APOSTOLIC DELEGATE

46. SIGNATURE OF APOSTOLIC NUNCIUS

47. SIGNATURE OF APOSTOLIC DELEGATE

48. SIGNATURE OF APOSTOLIC NUNCIUS

49. SIGNATURE OF APOSTOLIC DELEGATE

50. SIGNATURE OF APOSTOLIC NUNCIUS

51. SIGNATURE OF APOSTOLIC DELEGATE

52. SIGNATURE OF APOSTOLIC NUNCIUS

53. SIGNATURE OF APOSTOLIC DELEGATE

54. SIGNATURE OF APOSTOLIC NUNCIUS

BUREAU VI

JUL 12 1955

RECEIVED

RECEIVED

RECEIVED

RECEIVED

## CERTIFICATE OF DEATH

6158

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Rural Cumberland</u>				TOWN <u>Rural Cumberland</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		R.D. # 1.		STREET ADDRESS		(If rural give location)	
00				R.D. # 1.		/	
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Estella</u> (Middle) <u>May</u> (Last) <u>Moore</u>				(Month) <u>July</u> (Day) <u>24</u> (Year) <u>19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Widow</u>	<u>7-5-1886</u>	<u>69</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>Own Home</u>		<u>Maryland</u>		<u>U. S. A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>John E. O'Neal</u>				<u>Mary McDonald</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>None</u>		<u>Thomas Moore, Cash Valley Rd. R.D. 1</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
154X IMMEDIATE CAUSE (A) <u>cancer of the plethum</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 m.</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>arterial hypertension</u>				<u>years</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<u>6/21, 6/23/55</u>		<u>cancer of plethum, metastasizing to liver</u>					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> M.		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/10</u> , 19 <u>50</u> , to <u>July 24</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>7/10</u> , 19 <u>55</u> , and that death occurred at <u>3:15 P.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Wesley B. Briggs</u>				ADDRESS (Street, city, town, state) <u>55 Greene St.</u>		DATE SIGNED <u>7/26/55</u>	
M.D.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>July 28, 1955</u>		<u>St. Patricks Cemetery</u>		<u>Cumberland, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>July 27, 1955</u>		<u>Walter R. Frantz, M.D.</u>		<u>Charles L. George</u>		<u>Cumberland, Md.</u>	

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

# CERTIFICATE OF DEATH

For Use by

1. Name of Deceased

2. Sex

3. Date of Birth

4. Place of Birth

5. Date of Death

6. Cause of Death

7. Place of Death

8. Sex

9. Date of Death

10. Cause of Death

11. Date of Death

12. Sex

13. Cause of Death

14. Date of Death

15. Cause of Death

16. Date of Death

17. Cause of Death

18. Date of Death

19. Cause of Death

20. Date of Death

21. Cause of Death

22. Date of Death

23. Cause of Death

24. Date of Death

25. Cause of Death

26. Date of Death

27. Cause of Death

28. Date of Death

29. Cause of Death

30. Date of Death

31. Cause of Death

32. Date of Death

33. Cause of Death

34. Date of Death

35. Cause of Death

36. Date of Death

37. Cause of Death

38. Date of Death

39. Cause of Death

39. Date of Death

40. Cause of Death

BUREAU V. 8

JUL 29 1955

RECEIVED

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON  
BUREAU OF VITAL RECORDS  
RECEIVED JUL 29 1955  
JUL 29 1955

# 6117 CERTIFICATE OF DEATH

Reg. Dist. No. 4

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cumberland</u>		<u>12 hr. 10 Min</u>		TOWN <u>Cumberland, Rural</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sacred Heart Hospital</u>				STREET ADDRESS (If rural give location) <u>Locust Grove--Rt. #6</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Baby Girl</u> (Middle) <u>Morris</u> (Last)				(Month) (Day) (Year) <u>7/6/55</u> <u>19</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Single</u>	<u>7/6/55</u>	<u>7/6/55</u>	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>None</u>				<u>U.S.A. Cumberland, Md.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Francis Morris</u>				<u>Shirley Harper</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>None</u>		<u>Mother's Chart</u>			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
776X IMMEDIATE CAUSE (A)				<u>prematurity primary</u>			
ANTECEDENT CAUSE(S) DUE TO				<u>1 lb 5 oz. anoxia</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		INTERVAL BETWEEN ONSET AND DEATH	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		<u>12 hrs.</u>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7/6</u> , 19 <u>55</u> , to <u>7/6</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>7/6</u> , 19 <u>55</u> , and that death occurred at <u>3:24</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Elizabeth Briggs</u> M.D.				ADDRESS (Street, city, town, state) <u>55 Green W. Cumberland</u> DATE SIGNED <u>7/7/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>7-8-55</u>		<u>St. Joseph Cem.</u>		<u>Midland, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>July 8, 1955</u>		<u>Walter R. Frantz, M.D.</u>		<u>James F. Scarpelli</u>		<u>Cumberland, Md.</u>	

2075202240

# CERTIFICATE OF DEATH

Reg. Form No. 1

1. Name of deceased (Print or write)

2. Sex of deceased (Print or write)

3. Date of birth (Print or write)

4. Place of birth (Print or write)

5. Date of death (Print or write)

6. Place of death (Print or write)

7. Cause of death (Print or write)

8. Signature of physician (Print or write)

9. Signature of registrar (Print or write)

10. Signature of informant (Print or write)

11. Signature of witness (Print or write)

12. Signature of undertaker (Print or write)

13. Signature of funeral home (Print or write)

14. Signature of cemetery (Print or write)

15. Signature of burial place (Print or write)

16. Signature of interment place (Print or write)

17. Signature of final disposition (Print or write)

18. Signature of final disposition (Print or write)

19. Signature of final disposition (Print or write)

20. Signature of final disposition (Print or write)

21. Signature of final disposition (Print or write)

22. Signature of final disposition (Print or write)

23. Signature of final disposition (Print or write)

24. Signature of final disposition (Print or write)

25. Signature of final disposition (Print or write)

26. Signature of final disposition (Print or write)

27. Signature of final disposition (Print or write)

28. Signature of final disposition (Print or write)

29. Signature of final disposition (Print or write)

30. Signature of final disposition (Print or write)

31. Signature of final disposition (Print or write)

32. Signature of final disposition (Print or write)

33. Signature of final disposition (Print or write)

34. Signature of final disposition (Print or write)

35. Signature of final disposition (Print or write)

36. Signature of final disposition (Print or write)

37. Signature of final disposition (Print or write)

38. Signature of final disposition (Print or write)

39. Signature of final disposition (Print or write)

40. Signature of final disposition (Print or write)

41. Signature of final disposition (Print or write)

42. Signature of final disposition (Print or write)

43. Signature of final disposition (Print or write)

BUREAU V. 2

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# CERTIFICATE OF DEATH

06141

Reg. Dist. No. 4

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN - HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Allegany</b>		STATE <b>Maryland</b>		COUNTY <b>Allegany</b>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <b>Cumberland</b>		<b>60 Years</b>		TOWN <b>Cumberland</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS		STREET ADDRESS			
<b>542. Fairview Ave</b>		<b>542. Fairview Ave</b>		<b>542. Fairview Ave</b>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<b>Mary Ellen O'Rourke</b>				<b>July 30 19 55</b>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>
<b>Female</b>	<b>White</b>	<b>Widow</b>	<b>January 24 1873</b>	<b>82</b> yrs.	Months	Days	Hours Min.
<b>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE (State or foreign country)</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<b>House Wife</b>		<b>Own House</b>		<b>Vale Summit, Maryland</b>		<b>USA</b>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<b>John Creamer</b>				<b>Catherine Stanton</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)</b>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<b>No</b>		<b>None</b>		<b>John F. O'Rourke Cumberland, Md.</b>			
<b>18. MEDICAL CERTIFICATION</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>							
<b>422.2 IMMEDIATE CAUSE (A) <i>Myocardial Degeneration</i></b>							
<b>ANTECEDENT CAUSE(S) DUE TO</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO</b>							
<b>(C) <i>Partial Intestinal Obstruction</i></b>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/></b>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)</b>		<b>21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from 7/28, 1955, to 7/30, 1955, that I last saw the deceased alive on 7/28, 1955, and that death occurred at 6:18 P.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
<b>Lee H. Lee Jr.</b>		<b>Aug 2 1955</b>		<b>St Patricks Cemetery</b>		<b>Cumberland, Md.</b>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<b>Burial</b>		<b>White R. Prantz, M.D.</b>		<b>Byron Knight</b>		<b>Cumberland, Md.</b>	
<b>24. REC'D BY REGISTRAR</b>		<b>DATE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>			
<b>Aug 1, 1955</b>							



6119

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Allegany</b>		MARYLAND		STATE <b>MD.</b>		COUNTY <b>Allegany</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>02 TOWN Cumberland</b>		LENGTH OF STAY (in this place) <b>7 Days</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Lonaconing</b>		TOWN <b>X</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>62 Sacred Heart Hospital</b>				STREET ADDRESS <b>Jackson Street</b>			
3. NAME OF DECEASED (Type or Print) <b>James J. Phillips</b>				4. DATE OF DEATH (Month) (Day) (Year) <b>July 26th 1955</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Nov, 4th, 1884</b>	9. AGE last birthday <b>70</b> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Carpenter - Self-</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Lonaconing, MD.</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John S. Phillips</b>				14. MOTHER'S MAIDEN NAME <b>Isabel Ternent</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-055868</b>		17. INFORMANT & ADDRESS <b>Mrs. Estella Phillips (WIFE)</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION <b>Lonaconing, MD.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>	
IMMEDIATE CAUSE (A) <b>442X Uremia</b>							
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <b>nephrosclerosis</b>						<b>2 mo</b>	
(C) <b>Generalized Arteriosclerosis</b>						<b>3-4 yrs</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>Congestive Heart Failure</b>						<b>3 mo</b>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>70</b> , 19 <b>53</b> , to <b>26 July</b> , 19 <b>55</b> , that I last saw the deceased alive on <b>26 July</b> , 19 <b>55</b> , and that death occurred at <b>1200</b> A.M. from the causes and on the date stated above.							
SIGNATURE <b>George Richardson</b>				ADDRESS (Street, city, town, state) <b>Lonaconing, Md.</b>		DATE SIGNED <b>7/27/55</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>July 28th, 1955</b>		NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery, Lonaconing, MD.</b>		LOCATION (City, town, or county) (State) <b>Lonaconing, MD.</b>	
24. REC'D BY REGISTRAR <b>July 29, 1955</b>		REGISTRAR'S SIGNATURE <b>Walter R. Frantz, M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>George Eichhorn, Lonaconing, MD.</b>		ADDRESS	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

OK

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

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John S. Phillips

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• *Journal of Management Education* 24(1): 10-12

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

## I. PLACE OF DEATH:

COUNTY Allegany MARYLAND  
 CITY (If outside corporate limits, write RURAL OR and give nearest town) \_\_\_\_\_  
 TOWN Cumberland LENGTH OF STAY (in this place) 50 minutes  
 HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY Allegany  
 CITY (If outside corporate limits write RURAL and give nearest town) \_\_\_\_\_  
 OR TOWN Cumberland  
 STREET ADDRESS (If rural, give location) 11- Fifth St.

## 3. NAME OF DECEASED:

(First) Daisy (Middle) Elizabeth (Last) Priddy  
 (Type or Print)

4. DATE OF DEATH July 23 19 55  
 (Month) (Day) (Year)

## 5. SEX:

female  
 RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

## 8. DATE OF BIRTH:

March 1-1910

9. AGE last birthday: 45 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS.  
 Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Waitress: South End Republican Club.

10b. KIND OF BUSINESS OR INDUSTRY: \_\_\_\_\_

11. BIRTHPLACE (State or foreign country): Kessel, W. Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

## 13. FATHER'S NAME:

John Scott

## 14. MOTHER'S MAIDEN NAME:

Annie Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) no

## 16. SOCIAL SECURITY No.:

214-07-9137 (husband) Arthur Priddy

## 17. INFORMANT &amp; ADDRESS:

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

936.6  
Immediate cause

(a) Asphyxia due to ruptured larynx, also  
 DUE TO

## Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) Edema & hemorrhage of the epiglottis  
 DUE TO

(c) Coronary sclerosis (marked)

INTERVAL BETWEEN ONSET AND DEATH

1 hour

## II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

## 19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

## 20. AUTOPSY?

Yes ☐ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) So. End Republican Club, Cumberland

21c. (City or town) (County) (State)

Allegany 01 Md.

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY July 22-1955 P. M.

21e. INJURY OCCURRED While at work ☒ Not while at work ☐

21f. HOW DID INJURY OCCUR? Fight-2 men, iron chair thrown & accidentally hit

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☒, Undetermined cause ☐.

## SIGNATURE

H. V. Deming M.D.

CHIEF MEDICAL EXAMINER

DATE SIGNED July 23-1955

## 23. BURIAL, CREMATION, REMOVAL (Specify):

Burial

## DATE THEREOF

July 26, 1955

## NAME OF CEMETERY OR CREMATORY

Willcrest Burial Park

## LOCATION (City, town, or county) (State)

Cumberland, Maryland

## DATE REC'D BY LOCAL REG.

July 25, 1955

## REGISTRAR'S SIGNATURE

Walter R. Frantz, M.D.

## 24. FUNERAL DIRECTOR

James F. Scarpelli, "

## ADDRESS

"

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 28 1955

BUREAU Y. S.

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

6143

## CERTIFICATE OF DEATH

06144

9

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>ALLEGANY</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>ALLEGANY</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>22</u> TOWN <u>FROSTBURG</u>		LENGTH OF STAY (In this place) <u>3</u> DAYS		CITY (If outside corporate limits, write RURAL and give nearest town) <u>22</u> TOWN <u>FROSTBURG</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>61</u> <u>MINERS HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>1</u> <u>183 MCCULLOH ST.</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>SUSAN</u>		(Middle) <u>LEONA</u>		(Last) <u>RECKLEY</u>		(Month) <u>7</u> (Day) <u>12</u> (Year) <u>1955</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>9-17-1905</u>	9. AGE last birthday <u>49</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>EXAMINER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SHIRT FACTORY</u>		11. BIRTHPLACE (State or foreign country) <u>KIEFER, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>VINCENT S. RECKLEY</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET L. DALEY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>219-14-6884</u>		17. INFORMANT & ADDRESS <u>183 McCulloh St.</u> <u>Mrs. Lottie Beyans, Frostburg, Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
199.9 IMMEDIATE CAUSE (A) <u>Metastatic Malignancy of Liver</u>						<u>77</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Source Not yet determined</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Ulcerative Colitis</u>						<u>6 mo</u>	
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION <u>7</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> P. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from</b> <u>Feb</u> , 19 <u>53</u> , to <u>July 12</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>July 12</u> , 19 <u>55</u> , and that death occurred at <u>1:00 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>W. Mc Lane</u>		DATE THEREOF <u>7-15-55</u>		NAME OF CEMETERY OR CREMATORY <u>FROSTBURG MEMORIAL PARK</u>		LOCATION (City, town, or county) (State) <u>FROSTBURG, MD.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		24. REC'D BY REGISTRAR <u>7-16-55</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>PEARL H. MATTINGLY</u>		ADDRESS <u>23 E. MAIN</u> <u>FROSTBURG, MD.</u>	

# CERTIFICATE OF DEATH

MASSACHUSETTS

IN WARDEN'S OFFICE, BOSTON, ON DECEMBER 18, 1955

NAME OF DECEASED: **WILLIAM A. BROWN**

AGE: **68**

RESIDENCE: **123 NORTON ST., BOSTON, MASS.**

DATE OF DEATH: **12-18-55**

CAUSE OF DEATH: **HEART DISEASE**

PLACE OF DEATH: **HOME**

DATE OF BIRTH: **0-1-1887**

SEX: **MALE**

NAME OF DECEASED: **WILLIAM A. BROWN**

NAME OF DECEASED: **WILLIAM A. BROWN**

RESIDENCE: **123 NORTON ST., BOSTON, MASS.**

DATE OF BIRTH: **0-1-1887**

**BUREAU V. 2**

**JUL 18 1955**

**FILE**

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON, 18

MASSACHUSETTS

MASSACHUSETTS

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON, 18

1  
Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

6121

CERTIFICATE OF DEATH

06145

Reg. Dist. No. 4

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		MARYLAND		STATE MARYLAND		COUNTY ALLEGANY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN CUMBERLAND		6 DAYS		TOWN LONA CONING			
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) JOHN		(Middle) L.		(Last) RITCHIE		(Month) 7 - (Day) 24 - (Year) 1955	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		
MALE	WHITE	MARRIED	7/7/1880	75 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Retired Merchant - Plumbing Shop					MARYLAND		U.S.A.
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
DAVID RITCHIE				MARTHA LOVE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No				MEMORIAL HOSPITAL			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
177X IMMEDIATE CAUSE (A)				Uremia			
ANTECEDENT CAUSE(S) DUE TO				Carcinoma of Prostate ?			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		INTERVAL BETWEEN ONSET AND DEATH	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4-5 days	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July 23, 1955, to July 24, 1955, that I last saw the deceased alive on July 24, 1955, and that death occurred at 11:45 A.M. from the causes and on the date stated above.							
SIGNATURE		DATE		ADDRESS (Street, city, town, state)		DATE SIGNED	
W. P. Poyke Hodges		July 24, 1955		Cumberland, Md.		7/25/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		July 27, 1955		Oak Hill Cemetery		Lonaconing, Maryland.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
July 26, 1955		Walter R. Brant, M.D.		George Eichhorn, Lonaconing, Maryland.			

TABLE 1

04/10/2001

BUREAU V

JUL 28 1955

RECEIVED

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06146

## CERTIFICATE OF DEATH

Reg. Dist. No. 6

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Allegany</u>		STATE <u>Maryland</u> COUNTY <u>Allegany</u>					
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>THE BARTON</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>BARTON</u>					
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>		STREET ADDRESS (If rural give location) <u>1</u>					
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>Perry</u> <u>Ross</u>							
<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>July</u> <u>21</u> 19 <u>55</u>							
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>7 July 1894</u>				
9. AGE last birthday <u>61</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Beaterman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Paper Mill</u>					
11. BIRTHPLACE (State or foreign country) <u>BARTON, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>					
13. FATHER'S NAME <u>Henry H. Ross</u>		14. MOTHER'S MAIDEN NAME <u>MARY Ellen BROOKS</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>0</u>					
17. INFORMANT & ADDRESS <u>Mrs Perry Ross, BARTON, Md</u>							
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>			<b>18. MEDICAL CERTIFICATION</b>				
239X IMMEDIATE CAUSE (A) <u>Tumor of Chest</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 mo.</u>				
ANTECEDENT CAUSE(S) DUE TO (B) <u>arthritis -</u>			<u>20 yrs.</u>				
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>multiple myeloma</u>			<u>5 yrs.</u>				
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)					
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)							
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					
21f. HOW DID INJURY OCCUR?							
<b>22. I hereby certify that I attended the deceased from <u>July -</u>, 19 <u>40</u>, to <u>July 21</u>, 19 <u>55</u>, that I last saw the deceased alive on <u>July 21</u>, 19 <u>55</u>, and that death occurred at <u>6 P.</u> M, from the causes and on the date stated above.</b>							
SIGNATURE <u>P. E. Berry</u>		ADDRESS (Street, city, town, state) <u>Piedmont, W. Va.</u>					
DATE SIGNED <u>7-23-55</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>July 24, 55</u>					
NAME OF CEMETERY OR CREMATORY <u>Philos Cemetery</u>		LOCATION (City, town, or county) (State) <u>Westonport, Md.</u>					
24. REC'D BY REGISTRAR <u>Mr. Jon C. Kelly</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>E. L. Boal</u>					
DATE <u>7-24-55</u>		ADDRESS <u>Westonport</u>					

INSTRUCTIONS  
This form is to be filled out by the physician or other qualified person who has attended the deceased. It should be filled out as soon as possible after death, and should be submitted to the local health department or the Bureau of Health Statistics, Baltimore, Maryland, as soon as possible. The information furnished on this form is for the purpose of determining the cause of death and the manner of death, and is used for the purpose of compiling statistics on the causes of death and the manner of death. The information furnished on this form is confidential and should not be disclosed to anyone other than the health department or the Bureau of Health Statistics.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

00140

RECEIVED  
JUL 26 1955  
BUREAU V. S.

6122

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		MARYLAND		STATE WEST VIRGINIA		COUNTY MINERAL	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN CUMBERLAND		1 DAY		TOWN KEYSER		85X-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		MEMORIAL HOSPITAL		STREET ADDRESS		(If rural give location)	
60 MEMORIAL & WARWICK AVENUES				71 St. Cloud Street		✓	
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) CHARLES (Middle) P. (Last) RUDY				(Month) JULY (Day) 25 (Year) 1955			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
MALE	WHITE	WIDOWED	2-22-1865	90 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Ret. Foreman		W. Va. Pulp & Paper		W. VA. Wardensville		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
RUDY, DANIEL				RODEHEAVER, MARY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No				MEMORIAL HOSPITAL			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.0 IMMEDIATE CAUSE (A) <u>Uremia</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Heart disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Generalized Arteriosclerosis</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 7/20, 1955, to 7/25, 1955, that I last saw the deceased alive on 7/25, 1955, and that death occurred at 1:12 AM, from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
7/25/55				Cumberland, Md		7/25/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		7/27/1955		Queens Point Cemetery		Keyser, West Virginia	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
July 26, 1955		Walter R. Frank, M.D.		John J. Hafer, Cumberland, Maryland			

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

# CERTIFICATE OF DEATH

WEST VIRGIN

KEYSER

471 St. Clow

BUREAU V. 8

JUL 29 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** No. 4

## 1. PLACE OF DEATH:

COUNTY Allegheny MARYLAND  
 CITY (If outside corporate limits, write RURAL OR and give nearest town) Cumberland  
 TOWN Cumberland LENGTH OF STAY (In this place) 4 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY Allegheny  
 CITY (If outside corporate limits write RURAL and give nearest town) Cumberland  
 TOWN Cumberland

HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital

STREET ADDRESS (If rural, give location) 1120 Virginia Ave.

3. NAME OF DECEASED: (First) (Middle) (Last)  
 (Type or Print) Scott D. Shaffer

4. DATE OF DEATH (Month) (Day) (Year)  
July 15 19 55

5. SEX: male 6. COLOR OR RACE: white 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widower

8. DATE OF BIRTH: March 3-1885 9. AGE last birthday: 70 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS. Hours Min.

10. USUAL OCCUPATION (Give kind of work done during most of work life, specify if retired): Retired Doctor

10b. KIND OF BUSINESS OR INDUSTRY: Dr. Store

11. BIRTHPLACE (State or foreign country): Artemas, Pa. 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Shaffer

14. MOTHER'S MAIDEN NAME: Elsie Tewell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) no

16. SOCIAL SECURITY No.: 217-10-5088 17. INFORMANT & ADDRESS: Memorial Hospital records.

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

903.0  
 Immediate cause (a) Myocardial failure  
 Antecedent cause(s) (severe) arteriosclerotic cardiovascular disease with myocardial insufficiency also shock  
 Diseases or conditions, if any, giving rise to the above cause DUE TO open reduction of fractured left femur.  
 stating underlying cause last (c)

INTERVAL BETWEEN ONSET AND DEATH  
Gradual

4 days

## II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: July 12-1955 19b. MAJOR FINDING OF OPERATION: fracture of left femur. Open reduction-Comminuted intertrochanteric

20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING CAUSE OF DEATH ☒

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY Home

21c. (City or town) (County) (State)  
Cumberland Allegheny Md.

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY July 11/55-4A.M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☒

21f. HOW DID INJURY OCCUR? Started to walk, foot twisted, fell to the floor.

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

H.V. Deming M.D. H. V. Deming M.D. M. D. CHIEF MEDICAL EXAMINER ☐ DATE SIGNED July 15-1955  
 DEPUTY MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAM.

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG. July 18, 1955

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Dr. R. Grant, M.D. Louis' Stein, Inc., " " " " " "

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU VI 11

JUL 19 1955

RECEIVED

6124

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
02 TOWN <u>Cumberland</u>		25 yrs.		TOWN <u>Cumberland</u>		02	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
00 500 Park Street				500 Park Street			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last)				(Month) (Day) (Year)			
Ruth Viola Shaner				July 25 19 55			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Female	White	Married	March 30, 1898	57 yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Sewing Mch. Opr.				Cumb. Undergar-		Wittenburg, Pennsylvania	
12. CITIZEN OF WHAT COUNTRY?				U.S.A.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
John Hoover				Effie Murry			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
No				215-20-5142		W. Russell Shaner, Cumberland, Md.	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
155X IMMEDIATE CAUSE (A) Carcinomatosis, (Generalized)							
DUE TO ANTECEDENT CAUSE(S) (B) Primary, Carcinoma of liver							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> el work <input type="checkbox"/> el work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May</u> , 19 <u>55</u> , to <u>July</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>25 July</u> , 19 <u>55</u> , and that death occurred at <u>5</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Julius B. Harkins, M.D.</u>				ADDRESS (Street, city, town, state) <u>Cumberland, Md.</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		July 28, 1955		Hillcrest Burial Park		Cumberland, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
July 26, 1955		Walter R. Frantz, M.D.		John J. Hafer, Cumberland, Maryland			

## INSTRUCTIONS

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**2** **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Form 100-1-1-1

1. Name of deceased (Print or write full name)

2. Sex

3. Race

4. Date of birth

5. Place of birth

6. Usual residence (Print or write full name)

7. Date of death

8. Time of death

9. Cause of death (Print or write full name)

10. Place of death

11. Signature of physician

12. Signature of registrar

13. Signature of informant

14. Signature of witness

15. Signature of funeral director

16. Signature of undertaker

17. Signature of cemetery

18. Signature of burial society

19. Signature of religious society

20. Signature of other

21. Signature of

22. Signature of

23. Signature of

24. Signature of

25. Signature of

26. Signature of

27. Signature of

28. Signature of

29. Signature of

30. Signature of

31. Signature of

32. Signature of

33. Signature of

34. Signature of

35. Signature of

36. Signature of

37. Signature of

38. Signature of

39. Signature of

40. Signature of

41. Signature of

42. Signature of

43. Signature of

BUREAU V. S.

JUL 29 1935

RECEIVED

RECEIVED

RECEIVED

1. Within corporate limits.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06151

6125

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>ALLEGANY</b>		STATE <b>MARYLAND</b>		COUNTY <b>ALLEGANY</b>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <b>CUMBERLAND</b>		<b>8 DAYS</b>		TOWN <b>LITTLE ORLEANS</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>MEMORIAL HOSPITAL MEMORIAL &amp; WARWICK AVES.</b>				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<b>LOUIESA SHIPLEY</b>				<b>JULY 16 19 55</b>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days	<b>IF UNDER 24 HRS.</b> Hours Min.	
<b>FEMALE</b>	<b>WHITE</b>	<b>MARRIED</b>	<b>AUGUST 29, 1877</b>	<b>77</b>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)			<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>
<b>housewife</b>			<b>Own Home</b>		<b>PENNSYLVANIA, Bedford Co.</b>		<b>U.S.A.</b>
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<b>PETER CLINGERMAN</b>				<b>MARY POTTS</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)			<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>		
<b>No</b>			<b>None</b>		<b>Little Orleans Mrs. Olney Whitfield, Maryland</b>		
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>443X</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b>			
<b>IMMEDIATE CAUSE (A)</b>				<b>Since</b>			
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b>				<b>7/8/55</b>			
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b>				<b>Since</b>			
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)</b>		<b>21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from 7-8-55, to 7-16-55, that I last saw the deceased alive on 7-16-55, and that death occurred at 1:40 P.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b>				<b>ADDRESS</b> (Street, city, town, state)		<b>DATE SIGNED</b>	
<b>W. J. Williams, M.D.</b>				<b>Cumberland</b>		<b>7-16-55</b>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
<b>Burial</b>		<b>7/19/1955</b>		<b>Fairview Christian Cem.</b>		<b>Bedford County, Penn.</b>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<b>June 19, 1955</b>		<b>Walter R. Franz, M.D.</b>		<b>John J. Hafer, Cumberland, Maryland</b>			

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A19C 1-55 10M

# CERTIFICATE OF DEATH

6185

FILE NO.

1. DEATH CERTIFICATE NUMBER BY REGISTRAR

2. PLACE OF DEATH

3. NAME OF DECEASED

4. SEX

5. AGE

6. DATE OF DEATH

7. TIME OF DEATH

8. CAUSE OF DEATH

9. PLACE OF BIRTH

10. OCCUPATION

11. MARITAL STATUS

12. DATE OF MARRIAGE

13. NAME OF SPOUSE

14. NAME OF PHYSICIAN

15. NAME OF FUNERAL HOME

16. NAME OF MINISTER

17. NAME OF BURIAL PLACE

18. NAME OF NEXT OF KIN

19. NAME OF WITNESS

20. NAME OF REGISTRAR

21. NAME OF DECEASED (REPEAT)

22. SEX (REPEAT)

23. AGE (REPEAT)

24. DATE OF DEATH (REPEAT)

25. TIME OF DEATH (REPEAT)

26. CAUSE OF DEATH (REPEAT)

27. PLACE OF BIRTH (REPEAT)

28. OCCUPATION (REPEAT)

29. MARITAL STATUS (REPEAT)

30. DATE OF MARRIAGE (REPEAT)

31. NAME OF SPOUSE (REPEAT)

32. NAME OF PHYSICIAN (REPEAT)

33. NAME OF FUNERAL HOME (REPEAT)

34. NAME OF MINISTER (REPEAT)

35. NAME OF BURIAL PLACE (REPEAT)

36. NAME OF NEXT OF KIN (REPEAT)

37. NAME OF WITNESS (REPEAT)

38. NAME OF REGISTRAR (REPEAT)

39. NAME OF DECEASED (REPEAT)

40. SEX (REPEAT)

41. AGE (REPEAT)

42. DATE OF DEATH (REPEAT)

43. TIME OF DEATH (REPEAT)

44. CAUSE OF DEATH (REPEAT)

45. PLACE OF BIRTH (REPEAT)

46. OCCUPATION (REPEAT)

47. MARITAL STATUS (REPEAT)

48. DATE OF MARRIAGE (REPEAT)

49. NAME OF SPOUSE (REPEAT)

50. NAME OF PHYSICIAN (REPEAT)

51. NAME OF FUNERAL HOME (REPEAT)

52. NAME OF MINISTER (REPEAT)

53. NAME OF BURIAL PLACE (REPEAT)

54. NAME OF NEXT OF KIN (REPEAT)

55. NAME OF WITNESS (REPEAT)

56. NAME OF REGISTRAR (REPEAT)

57. NAME OF DECEASED (REPEAT)

58. SEX (REPEAT)

59. AGE (REPEAT)

60. DATE OF DEATH (REPEAT)

61. TIME OF DEATH (REPEAT)

62. CAUSE OF DEATH (REPEAT)

63. PLACE OF BIRTH (REPEAT)

64. OCCUPATION (REPEAT)

65. MARITAL STATUS (REPEAT)

66. DATE OF MARRIAGE (REPEAT)

67. NAME OF SPOUSE (REPEAT)

68. NAME OF PHYSICIAN (REPEAT)

69. NAME OF FUNERAL HOME (REPEAT)

70. NAME OF MINISTER (REPEAT)

71. NAME OF BURIAL PLACE (REPEAT)

72. NAME OF NEXT OF KIN (REPEAT)

73. NAME OF WITNESS (REPEAT)

74. NAME OF REGISTRAR (REPEAT)

75. NAME OF DECEASED (REPEAT)

76. SEX (REPEAT)

77. AGE (REPEAT)

78. DATE OF DEATH (REPEAT)

79. TIME OF DEATH (REPEAT)

80. CAUSE OF DEATH (REPEAT)

79. PLACE OF BIRTH (REPEAT)

80. OCCUPATION (REPEAT)

81. MARITAL STATUS (REPEAT)

82. DATE OF MARRIAGE (REPEAT)

83. NAME OF SPOUSE (REPEAT)

84. NAME OF PHYSICIAN (REPEAT)

BUREAU V. 2

MAY 21 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist.

No. 4

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY	Allegany		STATE	Md.	
CITY (If outside corporate limits, write RURAL OR and give nearest town)	TOWN Cumberland		CITY (If outside corporate limits write RURAL and give nearest town)	TOWN Cumberland	
HOSPITAL OR INSTITUTION OR STREET ADDRESS	910 Maryland Ave.		STREET ADDRESS	(If rural, give location) 910 Maryland Ave.	
3. NAME OF DECEASED:	(First)	(Middle)	(Last)	4. DATE OF DEATH	(Month) (Day) (Year)
(Type or Print)	John	Russell	Shoop	July	30 19 55
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR IF UNDER 24 HRS.
Male	white	Married	July 7-1880	75 yrs.	Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Retired Motor Wheel Worker-Lansing, Mich. (near) Hyndman, Pa.					U.S.A.
13. FATHER'S NAME:			14. MOTHER'S MAIDEN NAME:		
John Shoop			Laura Clites		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY No.:		
No			380-07-0892		
			17. INFORMANT & ADDRESS:		
			(wife) Nora Hillegas Shoop, City		

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
420.0 Coronary thrombous					
Immediate cause (a) DUE TO					
Antecedent cause(s) (b) DUE TO					
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)					
Sclerotic heart disease also had Chronic myocarditis				? over 2 years.	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE					
H.V. Deming M.D. H.V. Deming M.D. M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/> July 30-1955					
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
Buried		8/2/55		Hyndman Cemetery Hyndman Bedford Pa	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS	
July 30, 1955		Walter R. Frantz, M.D.		Harvey B. Ziegler Hyndman Pa	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

AUG 3 1955

RECEIVED

1. With a corporate limit

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06152

6127

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Allegany</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Allegany</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <b>Cumberland</b>		<b>11/9/50</b>		TOWN <b>Oldtown</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Allegany County Infirmary</b>				STREET ADDRESS (If rural give location) <b>Route #1</b>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <b>Owen</b> (Middle) <b>Ashford</b> (Last) <b>Slider</b>				(Month) <b>July</b> (Day) <b>4</b> (Year) <b>19 55</b>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<b>Male</b>	<b>White</b>	<b>Widower</b>	<b>12/15/1873</b>	<b>81</b>	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - Stone Mason</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
					<b>Maryland</b>		<b>U. S. A.</b>
13. FATHER'S NAME <b>William Slider</b>				14. MOTHER'S MAIDEN NAME <b>Mary Elizabeth Twigg</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT & ADDRESS <b>Allegany County Infirmary Records</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
422.1 IMMEDIATE CAUSE (A) <b>Pneumonia Hypostasis</b>						<b>72 hrs</b>	
ANTECEDENT CAUSE(S) DUE TO (B) <b>Chronic Nephritis</b>						<b>?</b>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <b>General Arteriosclerosis</b>						<b>?</b>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>osteo - arthrites</b>						<b>&gt;</b>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Jan. 2, 1953</b> to <b>July 4, 1955</b> , that I last saw the deceased alive on <b>July 3, 1955</b> , and that death occurred at <b>5:20 P.M.</b> from the causes and on the date stated above.							
SIGNATURE <b>James G. McLean</b> M.D.				ADDRESS (Street, city, town, state) <b>49 New St.</b>		DATE SIGNED <b>7-5-55</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>7-6-1955</b>		NAME OF CEMETERY OR CREMATORY <b>Slider Cemetery</b>		LOCATION (City, town, or county) (State) <b>Rt. 1. Old Town, Md.</b>	
24. REC'D BY REGISTRAR <b>July 6, 1955</b>		REGISTRAR'S SIGNATURE <b>Walter R. Bantz, M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George</b>		ADDRESS <b>Cumberland, Md.</b>	

## INSTRUCTIONS

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**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 AISC 1-55 10M

# CERTIFICATE OF DEATH

8193

Name of Deceased		Sex		Age	
John Doe		Male		45	
Date of Death		Place of Death		Cause of Death	
July 1, 1955		Home		Heart Disease	
Time of Death		Occupation		Manner of Death	
10:30 AM		Teacher		Natural	
Signature of Physician		Signature of Registrar		Signature of Coroner	
[Signature]		[Signature]		[Signature]	
Name of Hospital		Name of City		Name of State	
St. Mary's Hospital		Baltimore		Maryland	
Name of County		Name of District		Name of Precinct	
Anne Arundel County		District 1		Precinct 1	

BUREAU V. S.

JUL 8 1955

RECEIVED

JUL 11 1955

Director of Health

NOTIFICATION  
The undersigned hereby certifies that the foregoing is a true and correct copy of the original record of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the day and date above written.

NOTARIAL CERTIFICATE OF  
The undersigned hereby certifies that the foregoing is a true and correct copy of the original record of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the day and date above written.

6128

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>ALLEGANY</b>		STATE <b>MARYLAND</b>		COUNTY <b>Allegany</b>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <b>CUMBERLAND</b>		<b>25 DAYS</b>		TOWN <b>CUMBERLAND</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>MEMORIAL HOSPITAL</b>				STREET ADDRESS (If rural give location) <b>910 BEDFORD STREET</b>			
3. NAME OF DECEASED (Type or Print)		(First) <b>OLIVE</b>		(Middle) <b>A Manda</b>		(Last) <b>SMITH</b>	
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>MARRIED</b>		8. DATE OF BIRTH <b>FEB. 21, 1888</b>	
9. AGE last birthday <b>67</b> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
		Months		Days		Hours	
						Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>FLINTSTON MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>JOHN ROBINETTE</b>				14. MOTHER'S MAIDEN NAME <b>ELIZA HENDERSON</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>NO</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT & ADDRESS <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
171X IMMEDIATE CAUSE (A) <b>Adeno Carcinoma of Cervix</b>				<b>16 mos</b>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <b>0</b>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Feb. 16, 1955</b> , to <b>July 17, 1955</b> , that I last saw the deceased alive on <b>July 17, 1955</b> , and that death occurred at <b>1:00 PM</b> , from the causes and on the date stated above.							
SIGNATURE <b>Roger L. Bacon</b>				ADDRESS (Street, city, town, state) <b>M.D. 629 Pine St. Cumberland Md</b>		DATE SIGNED <b>7-17-55</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>7/20/1955</b>		NAME OF CEMETERY OR CREMATORY <b>Hillcrest Bur. Park</b>		LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
24. REC'D BY REGISTRAR <b>July 19, 1955</b>		REGISTRAR'S SIGNATURE <b>Walter L. Frantz, M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Md.</b>			

**INSTRUCTIONS**

**1. WITHIN 24 HOURS AFTER DEATH.** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**2. TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

**VS A15C 1-55 10M**

# CERTIFICATE OF DEATH

1925

NAME OF DECEASED J. J. J. J.		DATE OF DEATH JULY 21, 1925	
AGE 35 YEARS		SEX MALE	
PLACE OF BIRTH J. J. J. J.		PLACE OF DEATH J. J. J. J.	
OCCUPATION J. J. J. J.		CAUSE OF DEATH J. J. J. J.	
MANNER OF DEATH J. J. J. J.		SIGNATURE OF PHYSICIAN J. J. J. J.	
DATE OF BURIAL JULY 22, 1925		PLACE OF BURIAL J. J. J. J.	
NAME OF FUNERAL HOME J. J. J. J.		NAME OF MINISTER J. J. J. J.	
NAME OF CLERGYMAN J. J. J. J.		NAME OF CHURCH J. J. J. J.	
NAME OF HOSPITAL J. J. J. J.		NAME OF CITY J. J. J. J.	
NAME OF COUNTY J. J. J. J.		NAME OF STATE J. J. J. J.	

BUREAU A. 5

JUL 21 1925

RECEIVED

1

## INSTRUCTIONS

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**2** **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06154

6158

## CERTIFICATE OF DEATH

Reg. Dist. No. 6

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>BARTON</u>		<u>19 yrs</u>		TOWN <u>BARTON</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>				STREET ADDRESS (If rural give location) <u>1</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>MARGARET ETHELYNE Snyder</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>July 31 1955</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>25 Oct 1908</u>	9. AGE last birthday <u>46</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Beaming Dept</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Textile Mill</u>		11. BIRTHPLACE (State or foreign country) <u>Piedmont, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Edward Park</u>				14. MOTHER'S MAIDEN NAME <u>Winifred Guy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-09-8571</u>		17. INFORMANT & ADDRESS <u>Roy Snyder, Barton MD</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
156.1 IMMEDIATE CAUSE (A) <u>Carcinoma of Liver</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 Months</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION <u>Feb. 14, 1955</u>		19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of Liver</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify</b> that I attended the deceased from <u>Feb. 13, 1955</u> , to <u>July 31, 1955</u> , that I last saw the deceased alive on <u>July 30, 1955</u> , and that death occurred at <u>7 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Paul Wilson</u>				ADDRESS (Street, city, town, state) <u>Piedmont, W. Va.</u>		DATE SIGNED <u>Aug. 3, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>8-3-55</u>		NAME OF CEMETERY OR CREMATORY <u>Laurel Hill Cem.</u>		LOCATION (City, town, or county) (State) <u>Marshall, Allegany Co., Md.</u>	
24. REC'D BY REGISTRAR <u>8-3-55</u>		REGISTRAR'S SIGNATURE <u>Mr. J. C. Kelly</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. ...</u>			

BUREAU V. 8.

AUG 4 1955

RECEIVED

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A19C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

6129

# CERTIFICATE OF DEATH

06155

Reg. Dist. No. 4

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>02</u> TOWN <u>Cumberland</u>		LENGTH OF STAY (in this place) <u>6/2/49</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cumberland</u>		<u>02</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>91</u> <u>Allegany County Infirmary</u>				STREET ADDRESS (If rural give location) <u>74 Baltimore Avenue</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>Anna</u> <u>Christine</u> <u>Spoerl</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>July</u> <u>9</u> <u>19 55</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>1/27/1870</u>	9. AGE last birthday <u>85</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Cumberland, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>George M. Spoerl</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Herbig</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS <u>Allegany County Infirmary Records</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
592x IMMEDIATE CAUSE (A) <u>Chronic Myocarditis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>?</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>General arteriosclerosis</u>				<u>?</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Chronic Hepatitis</u>				<u>?</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Smile Dehydration</u>				<u>?</u>			
19a. DATE OF OPERATION <u>8</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 2, 19 52</u> , to <u>July 9, 19 55</u> , that I last saw the deceased alive on <u>July 9, 19 55</u> , and that death occurred at <u>6:15 P.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>James E. McLean M.D.</u>				ADDRESS (Street, city, town, state) <u>49 Greene St.</u>		DATE SIGNED <u>7-11-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>July 12, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>St. Lukes Cemetery</u>		LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
24. REC'D BY REGISTRAR <u>July 12, 1955</u>		REGISTRAR'S SIGNATURE <u>Walter R. Frantz, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein, Inc.</u>		ADDRESS <u>Cumberland Maryland</u>	

# CERTIFICATE OF DEATH

1955

U.S. Form No. 10

Name of Deceased George M. Brown		Date of Death July 14, 1955	
Sex Male		Age 68	
Race White		Marital Status Married	
Place of Birth New York, N.Y.		Usual Residence 123 Main St., Boston, Mass.	
Cause of Death Heart Disease		Date of Burial July 16, 1955	
Place of Burial Mount Hope Cemetery, Boston		Signature of Physician [Signature]	
Signature of Registrar [Signature]		Date of Registration July 15, 1955	

BUREAU V. 2

JUL 14 1955

RECEIVED

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON  
 BUREAU OF VITAL RECORDS  
 100 STATE STREET, BOSTON, MASS. 02109  
 TELEPHONE: 522-2200  
 FAX: 522-2200

1. Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06156

6130

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

**INSTRUCTIONS**  
**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>ALLEGANY</b>		STATE <b>MARYLAND</b>		COUNTY <b>ALLEGANY</b>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <b>CUMBERLAND</b>		<b>12 DAYS</b>		TOWN <b>CUMBERLAND</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>MEMORIAL HOSPITAL MEMORIAL AVE.</b>				STREET ADDRESS (If rural give location) <b>411 N. MECHANIC STREET</b>			
<b>3. NAME OF DECEASED</b> (Type or Print) <b>JOHN H. STOTTLEMYER</b>				<b>4. DATE OF DEATH</b> (Month) <b>JULY</b> (Day) <b>2,</b> (Year) <b>1955</b>			
<b>5. SEX</b> <b>MALE</b>	<b>6. COLOR OR RACE</b> <b>WHITE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED</b> (Specify) <b>MARRIED</b>	<b>8. DATE OF BIRTH</b> <b>MAY 6 1895</b>	<b>9. AGE last birthday</b> <b>60</b> yrs.	<b>IF UNDER 1 YEAR</b> Months <b>0</b> Days <b>0</b>	<b>IF UNDER 24 HRS.</b> Hours <b>0</b> Min. <b>0</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>BAKER</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>COMMUNITY BAKERY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>MARYLAND, Hancock</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>JAMES STOTTLEMYER</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>MARY Clingerman</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>220-10-2504</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>156.1 IMMEDIATE CAUSE</b> (A) <b>Carcinoma Liver</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>2 mo.</b>	
<b>ANTECEDENT CAUSE(S) DUE TO</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b> (B) <b>—</b>							
<b>(C) —</b>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b> <b>8/2/55</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, notify medical examiner) <input type="checkbox"/>		<b>21b. PLACE</b> (Home, farm, factory, of INJURY street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from 5/1/55, 1955, to 7/2/55, 1955, that I last saw the deceased alive on 7/2/55, and that death occurred at 6:15 P.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>W. Williams</i> M.D.				<b>ADDRESS</b> (Street, city, town, state) <b>Cumberland, Md.</b>		<b>DATE SIGNED</b> <b>7/2/55</b>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>7/5/55</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Hillcrest Burial Park</b>		<b>LOCATION</b> (City, town, or county) (State) <b>Cumberland, Md.</b>	
<b>24. REC'D BY REGISTRAR</b> <b>July 5, 1955</b>		<b>REGISTRAR'S SIGNATURE</b> <i>Walter R. Grant, M.D.</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>John J. Hafer, Cumberland, Md.</b>			

VS AISC 1-55 10M

RECEIVED

**INSTRUCTIONS**

**1. TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**2. TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06157

6131

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>ALLEGANY</b>		STATE <b>MARYLAND</b>		STATE <b>ILLINOIS</b>		COUNTY <b>COOK</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>02 TOWN CUMBERLAND</b>		LENGTH OF STAY (In this place) <b>1-DAY</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>OR TOWN CHICAGO</b>		<b>51X-3</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>60 MEMORIAL HOSPITAL</b>				STREET ADDRESS (If rural give location) <b>1633 NORTH CLEVELAND AVE. ✓</b>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <b>JAMES U. THEIS</b>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>JULY 3, 19 55</b>			
<b>5. SEX</b> <b>MALE</b>	<b>6. COLOR OR RACE</b> <b>WHITE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>SINGLE</b>	<b>8. DATE OF BIRTH</b> <b>APRIL 9, 1883</b>		<b>9. AGE last birthday</b> <b>72 yrs.</b>	<b>IF UNDER 1 YEAR</b> (Months) (Days) <b>IF UNDER 24 HRS.</b> (Hours) (Min.)	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>FATHER (REV.)</b>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>ILLINOIS</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>
<b>13. FATHER'S NAME</b> <b>JOHN THEIS</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>ANNA (Unknown)</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service) <b>Unknown</b>			<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>		
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>331X IMMEDIATE CAUSE (A)</b> <i>Cerebral hemorrhage</i>						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <i>7 hrs</i>	
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <i>Hypertension &amp; arteriosclerosis</i>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>			<b>19b. MAJOR FINDINGS OF OPERATION</b>			<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>			<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)		
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)			<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>		
<b>22. I hereby certify that I attended the deceased from 7/3/55, 19 to 7/3/55, 19, that I last saw the deceased alive on 7/3/55, 19, and that death occurred at 9:10 P.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>[Signature]</i>				<b>ADDRESS</b> (Street, city, town, state) <i>Cumberland</i>		<b>DATE SIGNED</b> <i>7/3/55</i>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>July 7, 1955</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Villa Redemer</b>		<b>LOCATION (City, town, or county)</b> <b>Glenview, Illinois</b>	
<b>24. REC'D BY REGISTRAR</b> <i>July 5, 1955</i>		<b>REGISTRAR'S SIGNATURE</b> <i>Winter R. Frank, M.D.</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>James F. Scarpelli, Cumberland, Md.</b>			

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE WHERE DEATH OCCURRED

NAME OF DECEASED

CHICAGO

1033 NORTH CLEVELAND AVE.

JULY 2, 1955

THIS

U.

JAMES

1955

WHITE

MALE

ILLINOIS

FATHER (35)

1033 NORTH CLEVELAND AVE.

CHICAGO, ILL.

IN MEDICAL EXAMINATION

BY PHYSICIAN

BUREAU V. S.

JUL 7 1955

RECEIVED

RECEIVED

## INSTRUCTIONS

**1. TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**2. TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06158

6132

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>ALLEGANY</b>		STATE <b>MARYLAND</b>		COUNTY <b>ALLEGANY</b>			
CITY (If outside corporate limits, write RURAL and give nearest town) <b>02</b>		LENGTH OF STAY (in this place) <b>33 DAYS</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>02</b>			
TOWN <b>CUMBERLAND</b>				TOWN <b>CUMBERLAND</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>60</b> <b>MEMORIAL HOSPITAL MEMORIAL AVENUE</b>				STREET ADDRESS (If rural give location) <b>531 PATTERSON AVENUE</b>			
<b>3. NAME OF DECEASED</b> (Type or Print) <b>BESSIE B. TWIGG</b>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>JULY 3, 1955</b>			
<b>5. SEX</b> <b>FEMALE</b>	<b>6. COLOR OR RACE</b> <b>WHITE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>MARRIED</b>	<b>8. DATE OF BIRTH</b> <b>JAN. 6, 1876</b>	<b>9. AGE last birthday</b> <b>79</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days	<b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>House</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Own House</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>PA.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>JOSEPH DEFFINBAUGH</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>SARAH SLIGER</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>None</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>MEMORIAL HOSPITAL, MEMORIAL AVENUE</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>443X</b> IMMEDIATE CAUSE (A) <b>Hypertensive Arterio</b>						<b>Since</b>	
ANTECEDENT CAUSE(S) DUE TO (B) <b>Sclerotic Cardio-vascular</b>						<b>1953</b>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <b>Disease</b>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)</b>		<b>21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work</b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from 5:10:00, 1955, to 7-3-55, that I last saw the deceased alive on 7-3-55, and that death occurred at 3:07 P.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>W. J. Williams</i> M.D.				<b>ADDRESS</b> (Street, city, town, state) <i>Cumberland</i>		<b>DATE SIGNED</b> <i>7-5-55</i>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>July 6 1955</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Hillcrest Burial Park</b>		<b>LOCATION (City, town, or county)</b> <b>Cumberland Md.</b>	
<b>24. REC'D BY REGISTRAR</b> <i>July 5, 1955</i>		<b>REGISTRAR'S SIGNATURE</b> <i>Walter R. Brantz, M.D.</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>J. H. Right</i>		<b>ADDRESS</b> <b>Cumberland, Md.</b>	

# CERTIFICATE OF DEATH

1955

REG. DIST. NO.

1. DECEASED'S NAME (LAST, FIRST, MIDDLE)

2. SEX (M/F) DATE OF BIRTH

3. PLACE OF BIRTH

4. OCCUPATION

5. MARITAL STATUS

6. DECEASED'S RESIDENCE

7. DECEASED'S USUAL PLACE OF DEATH

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. DATE OF DEATH

11. TIME OF DEATH

12. SIGNATURE OF DECEASED

13. SIGNATURE OF WITNESSES

14. SIGNATURE OF DECEASED

15. SIGNATURE OF WITNESSES

16. SIGNATURE OF DECEASED

17. SIGNATURE OF WITNESSES

BUREAU V. 3

JUL 7 1955

RECEIVED

RECEIVED

6133

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>ALLEGANY</b>		STATE <b>MARYLAND</b>		COUNTY <b>ALLEGANY</b>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
02 TOWN <b>CUMBERLAND</b>		10 DAYS		TOWN <b>OLDTOWN</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
60 <b>MEMORIAL HOSPITAL</b>				/			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <b>CORA</b> (Middle) <b>M.</b> (Last) <b>TWIGG</b>				(Month) <b>7/</b> (Day) <b>22/</b> (Year) <b>1955</b>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<b>FEMALE</b>	<b>WHITE</b>	<b>WIDOWED</b>	<b>JANUARY 15, 1881</b>	<b>74</b> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<b>House Wife</b>		<b>Own Home</b>		<b>MARYLAND</b>		<b>USA</b>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<b>CHARLES HAUGH</b>				<b>LYDIA PIPER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<b>No</b>		<b>None</b>		<b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
422.1 IMMEDIATE CAUSE (A)				<b>Chronic Myocarditis</b>			
ANTECEDENT CAUSE(S) DUE TO				<b>Arteriosclerosis</b>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH			
				<b>1 month</b>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> el work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>7/6/52</b> , 19____, to <b>7/22/55</b> , 19____, that I last saw the deceased alive on <b>7/22/55</b> , 19____, and that death occurred at <b>10:20 P.M.</b> , from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<b>C. Williams</b>				<b>Cumberland</b>		<b>7/25/55</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<b>Burial</b>		<b>7/25/55</b>		<b>Oldtown Cemetery</b>		<b>Oldtown, Maryland</b>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<b>July 25, 1955</b>		<b>Walter R. Frantz, M.D.</b>		<b>Louis Stein, Inc.</b>		<b>Cumberland, Md.</b>	

INSTRUCTIONS

**1** **WITHIN** **24** **HOURS** **AFTER** **DEATH.** The law requires that the death certificate be executed within 24 hours after death.

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this the bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this the bottom copy may be retained by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

# CERTIFICATE OF DEATH

FILED DATE 1955

1. DECEASED'S NAME (LAST, FIRST, MIDDLE)

2. DECEASED'S SEX AND AGE

3. DECEASED'S RACE

4. DECEASED'S SEX AND AGE

5. DECEASED'S RACE

6. DECEASED'S RACE

7. DECEASED'S RACE

8. DECEASED'S RACE

9. DECEASED'S RACE

10. DECEASED'S RACE

11. DECEASED'S RACE

12. DECEASED'S RACE

13. DECEASED'S RACE

14. DECEASED'S RACE

15. DECEASED'S RACE

16. DECEASED'S RACE

17. DECEASED'S RACE

18. DECEASED'S RACE

19. DECEASED'S RACE

20. DECEASED'S RACE

21. DECEASED'S RACE

22. DECEASED'S RACE

23. DECEASED'S RACE

24. DECEASED'S RACE

25. DECEASED'S RACE

26. DECEASED'S RACE

27. DECEASED'S RACE

28. DECEASED'S RACE

29. DECEASED'S RACE

30. DECEASED'S RACE

31. DECEASED'S RACE

32. DECEASED'S RACE

33. DECEASED'S RACE

34. DECEASED'S RACE

35. DECEASED'S RACE

36. DECEASED'S RACE

37. DECEASED'S RACE

BUREAU Y. S.

JUL 28 1955

RECEIVED

PHOTOCOPY

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

## 1. PLACE OF DEATH:

COUNTY Allegany MARYLAND  
CITY (If outside corporate limits, write RURAL OR and give nearest town) Cumberland LENGTH OF STAY (in this place)  
HOSPITAL OR INSTITUTION OR STREET ADDRESS Dead on arrival at the Memorial Hospital.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE W. Va. COUNTY Mineral  
CITY (If outside corporate limits write RURAL and give nearest town) Patterson Creek  
STREET ADDRESS (If rural, give location) 85x-3

3. NAME OF DECEASED: (First) (Middle) (Last)  
(Type or Print) Eugene Melvin Twigg

4. DATE OF DEATH (Month) (Day) (Year)  
July 11 19 55

5. SEX: male 6. COLOR OR RACE: white 7. SINGLE, MARRIED, WIDOWED, DIVORCED: married 8. DATE OF BIRTH: Sept 13-1898 9. AGE last birthday: 56 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Helper Bolt & Forge 10b. KIND OF BUSINESS OR INDUSTRY: B & O. R. Ry. 11. BIRTHPLACE (State or foreign country): Spring Gap, Md. 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William M. Twigg

14. MOTHER'S MAIDEN NAME: Virginia D. Eyler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) yes W.W.I

16. SOCIAL SECURITY No.: 705-12-5647

17. INFORMANT & ADDRESS: Patterson Creek, W. Va. (wife) Magdaline Logsdon Twigg

## 18. MEDICAL CERTIFICATION

### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

420.1  
Immediate cause (a) Coronary occlusion  
DUE TO  
Antecedent cause(s) (b) Coronary sclerosis  
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)

INTERVAL BETWEEN ONSET AND DEATH  
sudden

### II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?  
Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

21c. (City or town) (County) (State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.

21e. INJURY OCCURRED While nt work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

H.V. Deming M.D.

CHIEF MEDICAL EXAMINER ☐ DATE SIGNED July 11-1955  
DEPUTY MEDICAL EXAMINER ☒  
ASSISTANT MEDICAL EXAM. ☐

23. BURIAL, CREMATION, REMOVAL (Specify): Burial DATE THEREOF July 14, 1955 NAME OF CEMETERY OR CREMATORY Ft. Ashby Meth. Cem. LOCATION (City, town, or county) (State) Fort Ashby, West Va.

DATE REC'D BY LOCAL REG. July 14, 1955 REGISTRAR'S SIGNATURE Walter R. Hantz, M.D.

24. FUNERAL DIRECTOR John J. Hafer, Cumberland, Maryland ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 2

JUL 18 1955

RECEIVED

1  
Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

# CERTIFICATE OF DEATH

06161

Reg. Dist. No. 4

6135

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		MARYLAND		STATE MARYLAND		COUNTY ALLEGANY	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND		LENGTH OF STAY (In this place) 4 days		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND, rural		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 62 SAGRED HEART HOSPITAL				STREET ADDRESS ROUTE #4, Box 300		/	
3. NAME OF DECEASED (Type or Print) WILLIAM (First) LINDSEY (Middle) TWIGG (Last)				4. DATE OF DEATH (Month) (Day) (Year) 7- 13 19 55			
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH 6-1-1875	9. AGE last birthday 80 yrs.	IF UNDER 1 Year Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work during period of working life, even if retired) Calendar Room, Kelly-Springfield Tire Co.				10b. KIND OF BUSINESS OR INDUSTRY MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME HORACE TWIGG				14. MOTHER'S MAIDEN NAME LOWENA MIDDLETON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No				16. SOCIAL SECURITY NO. 214-05-9901		17. INFORMANT & ADDRESS CHART	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 422.1 IMMEDIATE CAUSE (A) Congestive Heart Failure ANTECEDENT CAUSE(S) DUE TO (B) Arteriosclerotic Cerebrovascular Disease DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Advanced Age - Hypertrophic Heart				18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH 4 days			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July 9, 19 55, to July 12, 19 55, that I last saw the deceased alive on July 12, 19 55, and that death occurred at 8:35 P.M. from the cause and on the date stated above.							
SIGNATURE Hennel Wright				ADDRESS (Street, city, town, state) M.D. 1330a Ave, Cumberland Md		DATE SIGNED 7/13/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF July 16, 1955		NAME OF CEMETERY OR CREMATORY Mt. Tabor Meth. Cem		LOCATION (City, town, or county) Spring Exp, Maryland	
24. REC'D BY REGISTRAR July 14, 1955		REGISTRAR'S SIGNATURE Winter L. Frantz, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE John J. Hager		ADDRESS Cumberland, Md	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

# CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. SEX

3. AGE

4. RACE

5. OCCUPATION

6. PLACE OF BIRTH

7. DATE OF BIRTH

8. PLACE OF DEATH

9. TIME OF DEATH

10. CAUSE OF DEATH

11. MEDICAL HISTORY

12. PHYSICIAN'S SIGNATURE

13. SIGNATURE OF DECEASED

14. SIGNATURE OF WITNESSES

15. SIGNATURE OF REGISTRAR

16. SIGNATURE OF CLERK

17. SIGNATURE OF JURY

18. SIGNATURE OF JUDGE

19. SIGNATURE OF SHERIFF

20. SIGNATURE OF CONSTABLE

21. SIGNATURE OF TOWNSHIP CLERK

22. SIGNATURE OF COUNTY CLERK

23. SIGNATURE OF STATE CLERK

24. SIGNATURE OF FEDERAL CLERK

25. SIGNATURE OF MARSHAL

26. SIGNATURE OF SHERIFF

27. SIGNATURE OF CONSTABLE

28. SIGNATURE OF TOWNSHIP CLERK

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257. SIGNATURE OF SHERIFF

258. SIGNATURE OF CONSTABLE

259. SIGNATURE OF TOWNSHIP CLERK

**INSTRUCTIONS**  
**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

6136

CERTIFICATE OF DEATH

Reg. Dist. No. ....

06162

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Allegany</u>		STATE <u>Maryland</u> COUNTY <u>Allegany</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		LENGTH OF STAY (in this place) <u>5/4/53</u>		TOWN <u>Cumberland</u>		TOWN <u>Cumberland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Allegany County Infirmary</u>				STREET ADDRESS (If rural give location) <u>508 Victoria Street</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) (First) (Middle) (Last) <u>Adam Henry Weisenmiller</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>July 13, 1955</u>			
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Widower</u>		<b>8. DATE OF BIRTH</b> <u>3/8/1870</u>	
<b>9. AGE</b> last birthday <u>85</u> yrs.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired Machinist - B. &amp; O.</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Cumberland, Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>	
<b>13. FATHER'S NAME</b> <u>John Weisenmiller</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Anna Schilling</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>None</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Allegany County Infirmary Records</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>199.9 IMMEDIATE CAUSE</b> (A) <u>Chronic Myocarditis</u>						<u>?</u>	
<b>ANTECEDENT CAUSE(S) DUE TO</b> (B) <u>General Carcinomatosis</u>						<u>?</u>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b> (C) <u>Cerebral Arteriosclerosis -</u>						<u>?</u>	
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <u>Senile Deterioration</u>						<u>?</u>	
<b>19a. DATE OF OPERATION</b> <u>0</u>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify</b> that I attended the deceased from <u>May 4, 1955</u> to <u>July 13, 1955</u> , that I last saw the deceased alive on <u>July 12, 1955</u> , and that death occurred at <u>8 A. M.</u> from the causes and on the date stated above.							
<b>SIGNATURE</b> <u>James E. McLean</u> M.D.				<b>ADDRESS</b> (Street, city, town, state) <u>49 Greene St. Cumberland, MD</u>		<b>DATE SIGNED</b> <u>7-13-55</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>July 15 1955</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Rose Hill Mausoleum</u>		<b>LOCATION (City, town, or county)</b> <u>Cumberland, MD</u>	
<b>24. REC'D BY REGISTRAR</b> <u>July 14, 1955</u>		<b>REGISTRAR'S SIGNATURE</b> <u>Winter R. Frantz, M.D.</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>W. H. Wright</u>		<b>ADDRESS</b> <u>Cumberland, MD.</u>	

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6137

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Allegany</u>		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cumberland</u>		<u>4/22/53</u>		TOWN <u>Cumberland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Allegany County Infirmary</u>				STREET ADDRESS (If rural give location) <u>207 Carroll Street</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>Mary</u>		(Middle) <u>E.</u>		(Last) <u>Willard</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>		8. DATE OF BIRTH <u>April 3, 1876</u>	
9. AGE last birthday <u>79</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
		Months		Days		Hours	
						Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland Cumberland,</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>John Wegman</u>				14. MOTHER'S MAIDEN NAME <u>Nancy Hughes</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Allegany County Infirmary Records</u>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
IMMEDIATE CAUSE (A) <u>443X</u>				<u>Chronic myocarditis</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</u>				<u>Coronary Arteriosclerosis</u>			
				<u>Hypertension</u>			
				<u>Senile Deterioration</u>			
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 4, 1953</u> to <u>July 30, 1955</u> , that I last saw the deceased alive on <u>July 27, 1955</u> , and that death occurred at <u>3:20</u> M., from the causes and on the date stated above.							
SIGNATURE <u>James B. McLean</u> M.D.				DATE SIGNED <u>7-30-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>8/2/55</u>		NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cem.</u>		LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
24. REC'D BY REGISTRAR <u>Aug. 3, 1955</u>		REGISTRAR'S SIGNATURE <u>Walter R. Frantz, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>H. Wayne George</u> ADDRESS <u>Cumberland, Md.</u>			

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

# CERTIFICATE OF DEATH

Reg. No. 100

1. Name of deceased (Print or Write)

2. Sex (Male or Female)

3. Age

4. Date of death

5. Time of death

6. Place of death

7. Cause of death (Print or Write)

8. Signature of physician

9. Signature of registrar

10. Date of registration

11. Signature of registrar

12. Signature of registrar

13. Signature of registrar

14. Signature of registrar

15. Signature of registrar

16. Signature of registrar

17. Signature of registrar

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19. Signature of registrar

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25. Signature of registrar

26. Signature of registrar

27. Signature of registrar

28. Signature of registrar

29. Signature of registrar

30. Signature of registrar

31. Signature of registrar

32. Signature of registrar

33. Signature of registrar

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AUG 4 1955

RECEIVED

14. Signature of registrar

15. Signature of registrar

16. Signature of registrar

17. Signature of registrar

Within corporate limits

06164

CERTIFICATE OF DEATH

Reg. Dist. No. 4

6133

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY ALLEGANY	MARYLAND	STATE MARYLAND	COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL OR and give nearest town) 02 CUMBERLAND	LENGTH OF STAY (in this place) 6 DAYS	CITY (If outside corporate limits, write RURAL and give nearest town) Near CUMBERLAND, Rural	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS 60 MEMORIAL HOSPITAL		STREET ADDRESS RT.#2	(If rural give location)

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year)	
ELLA K. WITTIG		JULY 28 1955	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH NOVEMBER 7, 1884
9. AGE last birthday 70 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Social Nurse		10b. KIND OF BUSINESS OR INDUSTRY Hoschild-Kohn	11. BIRTHPLACE (State or foreign country) MARYLAND Hyattsville
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME THOMAS W. BROWN Co.	
14. MOTHER'S MAIDEN NAME MARY BIDDISON		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No	
16. SOCIAL SECURITY NO. 212-03-3473		17. INFORMANT & ADDRESS MEMORIAL HOSPITAL, CUMBERLAND, MD.	

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
181X IMMEDIATE CAUSE (A) Metastatic Carcinoma				2 mos	
ANTECEDENT CAUSE(S) DUE TO (B) Carcinoma of Bladder				3 yrs	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) M.		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 22 July, 1955, to 28 July, 1955, that I last saw the deceased alive on 28 July, 1955, and that death occurred at 1:25 A.M. from the causes and on the date stated above.					
SIGNATURE James E. Stegmaier		M.D. Cumberland, Md		DATE SIGNED 7/30/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Aug. 1, 1955		NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Park	
				LOCATION (City, town, or county) Baltimore, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE Walter R. Frantz, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland	
				ADDRESS	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 A15C 1-55 10M



6139  
CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		MARYLAND		STATE MARYLAND		COUNTY ALLEGANY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN CUMBERLAND, MD.		5 DAYS		TOWN CUMBERLAND			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
60 MEMORIAL HOSPITAL				730 EAST OLDTOWN ROAD			
3. NAME OF DECEASED (Type or Print)		(First) CLYDE		(Middle) T.		(Last) WOLFORD	
						4. DATE OF DEATH (Month) (Day) (Year)	
						JULY 16 19 55	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
MALE	WHITE	MARRIED	JULY 28, 1912	42 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Fireman			B. & O. R. R. Co.		MARYLAND, Cumberland		U.S.A.
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
CHARLES T. WOLFORD				MILA LEYDIG			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No		(If Yes, give war or dates of service)		214-07-3792 Memorial Hospital			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							INTERVAL BETWEEN ONSET AND DEATH
002X IMMEDIATE CAUSE (A) Tuberculous Pneumonia							5 days
ANTECEDENT CAUSE(S) DUE TO (B) Miliary Tuberculosis							2 months
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> et work et work		21f. HOW DID INJURY OCCUR?			
		M.					
22. I hereby certify that I attended the deceased from Jan 1955, to July 16, 1955, that I last saw the deceased alive on July 16, 1955, and that death occurred at 10:28 A.M. from the causes and on the date stated above.							
SIGNATURE		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		July 19, 1955		Lybarger Cemetery		Madley, Pennsylvania.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
July 18, 1955		Walter R. Frantz, M.D.		James F. Scarpelli, Cumberland, Maryland.			

## INSTRUCTIONS

**1** **With corporate limits**

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VS AISC 1-55 10M

# CERTIFICATE OF DEATH

WAS DIED

IN HIS OWN HOME

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF DEATH

PERIOD OF ILLNESS

DATE OF DEATH

100 EAST CLAYMAN ROAD

CLAYMAN & WILSON AVENUE

WOLFOOD

CLAY

JULY 25, 1955

WOLFOOD

WOLFOOD

WOLFOOD

WOLFOOD

BUREAU V. B.

JUL 19 1955

RECEIVED

NOTICE: This certificate is to be used only for the purpose of recording a death and for the purpose of obtaining a burial permit. It is not to be used for any other purpose. The information furnished on this certificate is to be used only for the purpose of recording a death and for the purpose of obtaining a burial permit. It is not to be used for any other purpose.